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Volume 66

JANUARY 1967—DECEMBER 1967

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Alternates

J. C. Fox, La Crosse, 1968
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List of Officers and Scheduled Meetings of County Medical Societies

COUNTY	PRESIDENT	SECRETARY	MEETING DATE
Ashland–Bayfield–Iron	Harold Guzzo Washburn	C. A. Grand 206–6th Ave., W., Ashland	
Barron–Washburn–Sawyer–Burnett	John K. Hoyer Rice Lake	John Henningsen 24 W. Marshall, Rice Lake	Second Tuesday 7:30 p.m.
Brown	Francis B. Vande Loo Wrightstown	K. C. Mickle 3319 Delahaut Green Bay	Second Thursday*
Calumet	John A. Knaut Stockbridge	J. C. Pinney Hilbert	
Chippewa	Robert Mathwig Stanley	Frank B. Sazama 133 W. Central St. Chippewa Falls	Second Tuesday
Clark	J. W. Koch Colby	Bahri Gungor Neillsville	
Columbia–Marquette–Adams	Thomas S. Westcott 115 W. Chestnut Pardeeville	Frederick H. Bronson 310 W. Conant St. Portage	Every Third Month 7:00 p.m.
Crawford	James R. Wong 229 S. Michigan St. Prairie du Chien	H. L. Shapiro Prairie du Chien	Third Wednesday
Dane	C. K. Kincaid City–County Bldg. Room 507, Madison	E. L. Belknap, Jr. 20 S. Park St. Madison	Second Tuesday**
Dodge	Theodore Rowan Box 512 Beaver Dam	Richard A. Damon 708 Scott St. Beaver Dam	Last Thursday*
Door–Kewaunee	Nicholas R. Wagener 802 North 3rd Ave. Sturgeon Bay	Reynold M. Nesemann 213 Ellis St. Kewaunee	
Douglas	Victor E. Ekblad 1507 Tower Ave., Superior	Robert Sellers 2209 E. 5th St., Superior	First Wednesday* Hotel Superior
Eau Claire–Dunn–Pepin	William T. Mautz 204 E. Grand Ave. Eau Claire	Lou A. Raymond 605 Walker Ave. Eau Claire	Last Monday
Fond du Lac	Russell S. Pelton 416 Watson St. Ripon	John G. Parrish, Jr. 1921 Mulen Drive Fond du Lac	Fourth Thursday*
Forest	E. F. Castaldo Laona	D. V. Moffet, Crandon	
Grant	Paul K. Edwards Bloomington	H. W. Carey 257 Madison St., Lancaster	Last Thursday, March, June, Sept. and Nov.
Green	Leslie G. Kindschi 1770 13th St. Monroe	James H. Weeks 921 16th Ave., Monroe	
Green Lake–Waushara	Steve R. Osicka 147 N. State St., Berlin	Erich M. Schmidt P. O. Box 48, Berlin	Last Thursday, every other month starting in Jan.

* Except June, July and August. ** Except July and August

the wisconsin medical journal

Official Publication of THE STATE MEDICAL SOCIETY OF WISCONSIN

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1967 WISCONSIN

Feb. 3–5: Annual scientific meeting, Wisconsin Psychiatric Association, Oshkosh.

Feb. 8: "In Depth" surgery program on "Fractures and Other Highway Trauma," sponsored by the State Medical Society's CES Foundation, presented by the University of Wisconsin Medical School, Madison.

Feb. 13–24: Advanced maternity program in delivery room nursing, Marquette University College of Nursing, Milwaukee.

Feb. 14–16: Fourth annual Mt. Telemark Symposium and Ski Outing, sponsored by Indianhead Chapter of the Wisconsin Academy of General Practice, Cable.

Feb. 25: Winter scientific program of Wisconsin Otolaryngological Society, University of Wisconsin Medical School, Madison.

Mar. 6–17: Advanced maternity program in delivery room nursing, Marquette University College of Nursing, Milwaukee.

Mar. 9: "In Depth" program on "Cardiac Emergencies and Intensive Care," sponsored by the State Medical Society's CES Foundation, presented by the University of Wisconsin Medical School, Madison.

Mar. 30–31: Annual meeting, Wisconsin Anti-Tuberculosis Association, Milwaukee.

Apr. 6–8: Postgraduate conference on "The Mentally Retarded Child," sponsored by the Department of Pediatrics, University of Wisconsin.

Apr. 10–21: Advanced maternity program in delivery room nursing, Marquette University College of Nursing, Milwaukee.

Apr. 12–13: Second annual postgraduate conference on prevention and management of athletic injuries, sponsored by University of Wisconsin Medical Center, Wisconsin Center building, Madison.

May 9–11: State Medical Society annual meeting, Milwaukee.

May 20: Annual meeting, Wisconsin Heart Association, Milwaukee.

Sept. 14: Symposium on stroke, sponsored by the Wisconsin Heart Association and the Adolf Gundersen Medical Foundation, La Crosse.

Oct. 16–20: Wisconsin Work Week of Health, State Medical Society of Wisconsin, Madison.

1967 NEIGHBORING STATES

Feb. 6–10: Postgraduate course in "Biochemical Mechanisms in Internal Medicine," presented by the American College of Physicians, at Washington University, St. Louis, Mo.

Feb. 8: "Deafness and Dizziness—How Do We Stand?" fifth in a series of programs by the University of Chicago Hospitals and Clinics.

Feb. 20–22: Postgraduate course in internal medicine (hematology), University of Minnesota, Minneapolis.

Feb. 24–25: Postgraduate course in neurosurgery, University of Minnesota, Minneapolis.

Mar. 8: "Nature and Management of Inflammatory Bowel Disease," sixth in a series of programs by the University of Chicago Hospitals and Clinics.

Mar. 13–17: Postgraduate course in proctology, University of Minnesota, Minneapolis.

Mar. 20–24: Postgraduate course in "Fundamental Concepts of Gastroenterology," sponsored by the American College of Physicians, at the University of Michigan, Ann Arbor.

Mar. 20–24: American College of Physicians postgraduate course, "Fundamental Concepts of Gastroenterology," University of Michigan Medical Center, Ann Arbor.

Mar. 27–31: American College of Physicians postgraduate course, "Psychiatry for the Internist," Wayne State University School of Medicine, Detroit.

Mar. 27–31: Postgraduate course in "Psychiatry for the Internist," sponsored by the American College of Physicians, at Wayne State University, Detroit, Mich.

Apr. 7–8: Postgraduate course in trauma, University of Minnesota, Minneapolis.

MEDICAL MEETINGS

POSTGRADUATE COURSES

Apr. 10–22: Postgraduate course in laryngology and bronchoesophagology, Illinois Eye and Ear Infirmary, Chicago.

Apr. 12: "Endocrines and the Reproductive System," seventh in a series of programs by the University of Chicago Hospitals and Clinics.

Apr. 19–22: 11th Annual Postgraduate Course on Fractures and Other Trauma, sponsored by American College of Surgeons, John B. Murphy Auditorium, Chicago.

Apr. 27–29: Postgraduate course in obstetrics, University of Minnesota, Minneapolis.

May 1–3: Postgraduate course in ophthalmology, University of Minnesota, Minneapolis.

May 10: "Head Injuries," eighth in a series of programs by the University of Chicago Hospitals and Clinics.

May 25–27: Postgraduate course in surgery, University of Minnesota, Minneapolis.

June 1–3: Postgraduate course in anesthesiology, University of Minnesota, Minneapolis.

June 12–15: Catholic Hospital Association convention, Chicago.

June 19–21: Postgraduate course in "Clinical Applications—Recent Advances in Pharmacology," presented by the American College of Physicians, at the University of Iowa, Iowa City.

Oct. 2–6: Annual clinical congress, American College of Surgeons, Chicago.

1967 OTHERS

Mar. 6–9: 30th annual New Orleans Graduate Medical Assembly, New Orleans, La.

May 3: Scientific session, American Cancer Society, Dallas, Tex.

For listing of other meetings see the JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION.

Mt. Telemark Symposium

The fourth annual Mt. Telemark Symposium and Ski Outing, sponsored by the Indianhead Chapter of the Wisconsin Academy of General Practice, will be held Tuesday, Wednesday, and Thursday, February 14, 15 and 16, at Mt. Telemark, Cable.

The three-day scientific program, as in the past, will be presented by a faculty from the Mayo Clinic. The meeting is open to all physicians. There is no registration fee.

Participants are asked to make their own motel accommodations. Information on lodging may be obtained by writing to the Manager, Mt. Telemark Ski Area, Cable, Wis., or phone (715) 798–3311.

Mt. Telemark, with its own snow-making equipment, is one of the finest ski areas in the midwest. There are ten slopes, three T-bars, 10 rope tows and a chair lift. Excellent for expert or novice. All equipment can be rented. For more information about the meeting contact the Wisconsin Academy of General Practice, 2825 N. Mayfair Rd., Milwaukee, Wis. 53222.

ACP Presents Course for Internists

The American College of Physicians will present a postgraduate course in "Biochemical Mechanisms in Internal Medicine," February 6–10 at Washington University School of Medicine, St. Louis, Mo.

This course is to emphasize the importance of biochemical considerations as they relate to the etiology, pathogenesis, clinical phenomena, and therapy of various disorders encountered in internal medicine. The application of these considerations to genetics, metabolism, hematology, allergy, immunology, arthritis, hypertension, gastroenterology, and infections, renal, muscle, and cardiovascular diseases will be illustrated by a series of lectures.

The fee for the course is $60 for ACP members, $100 for nonmembers. For information and registration, write Edward C. Rosenow, Jr., M.D., Executive Director, American College of Physicians, 4200 Pine St., Philadelphia, Pa. 19104.

Industrial Health Conference Scheduled

The 1967 American Industrial Health Conference will be held April 10–13 in New York City, it has been announced by the Industrial Medical Association and the American Association of Industrial Nurses.

This medical-nursing conference, which is comprised of the annual meetings of the two associations, will bring together about 2,500 persons who, in addition to industrial physicians and nurses, will include industrial hygienists, safety engineers, public health officials, military service medical personnel, university faculty members, management representatives, and others who have an interest in the health of the working population.

For details write American Industrial Health Conference, 55 East Washington St., Chicago, Ill. 60602.

Orthopsychiatric Association Meeting

About 9,000 people are expected to attend the 44th annual meeting of the American Orthopsychiatric Association March 20–23 in Washington, D.C. This year's theme will be "The Impact of Schools in Human Development—A Critical Appraisal of a Social Institution."

There will be 65 sessions, 30 panels, and 52 workshops devoted to basic clinical and social problems of concern to the mental health field. Program topics will include American youth in a social struggle—the Appalachian volunteers; identifying the gifted child in a culturally deprived population; training and use of "poor" adults in mental health and education programs; and the family in a society in transition.

A post-conference meeting will be held in Kingston, Jamaica, March 27–29 at the invitation of and in collaboration with the University of the West Indies and the Jamaican Ministries of Education, Development and Welfare, and Health. The meeting theme will be "Impact of Education on Human Development."

Non-members are welcome at the meetings. For more details and registration forms, write Marion Langer, Ph.D., Executive Secretary, American Orthopsychiatric Association, 1790 Broadway, New York, N. Y. 10019.

National Conference on Rural Health

"Rural–Urban Health Relationships" will be the theme of the 20th National Conference on Rural Health March 10–11 in Charlotte, N. C.

The purpose of the conference is to explore new needs and report on new developments in the following: community planning and responsibility for health facilities and services, future patterns of personal health care, rural accident prevention and first aid instruction, and planning and utilizing health manpower.

For more details, write Bond L. Bible, Ph.D., Council on Rural Health, American Medical Association, 535 North Dearborn St., Chicago, Ill. 60610.

New York Symposium on Cutaneous Disease

A symposium on "Immunologic Approaches to Mechanisms of Cutaneous Disease" will be presented March 29–31 at the New York University Medical Center by the departments of dermatology and medicine.

Presentations will cover important aspects of the formation, structure and function of antibody, present status of delayed hypersensitivity, autosensitization, role of various immunocompetent cell populations and pharmacologic mediators of tissue damage. Immunologic aspects of cutaneous infectious diseases, contact dermatitis, photoallergis dermatitis, allergic drug eruptions, urticaria and atopic dermatitis will be discussed.

Information concerning registration may be obtained by writing: Office of the Recorder, New York University Post-Graduate Medical School, New York, N. Y. 10016.

New Orleans Graduate Medical Assembly

The New Orleans Graduate Medical Assembly will hold its 30th annual meeting March 6–9 in New Orleans.

On the program are 19 guest speakers and 51 discussions, in addition to clinicopathologic conferences, symposia, and roundtable luncheons. This program is acceptable for 30½ accredited hours by the American Academy of General Practice.

For details, write Secretary, The New Orleans Graduate Medical Assembly, 1430 Tulane Ave., Room 1528, New Orleans, La. 70112.

Symposium on Stroke Planned

The Wisconsin Heart Association and the Adolf Gundersen Medical Foundation will sponsor a symposium on stroke September 14 in La Crosse.

Catholic Hospital Association Convention

"Crises in Health Care Management" will be the theme of the Catholic Hospital Association convention, to be held June 12–15 in Chicago.

Topics will be geared to extended care facilities, nursing homes, and hospitals. The "crises" will be related to all management levels of health care institutions, with special emphasis on the problems of middle managers. Topics will include "The Role of Religion in Management;" "Middle Management—The Key to Effectiveness;" and "The Federal Government's Influence."

For further information, write Catholic Hospital Association, 1438 South Grand Blvd., St. Louis, Mo. 63104.

Rheumatology Congress in Mexico City

The fourth Panamerican Congress of Rheumatology will be held October 22–26 in Mexico City. For information write General Secretary, Dr. Gabor Katona, Ave. Cuauhtemoc 300, Mexico 7, D. F., Mexico.

Courses at University of Colorado

Eight medical postgraduate courses have been scheduled by the University of Colorado School of Medicine. For information and detailed programs, write The Office of Postgraduate Medical Education, University of Colorado School of Medicine, 4200 East Ninth Ave., Denver, Colo. 80220.

The upcoming courses are Clinical Dermatology—April 27–29; Marriage Counseling for Physicians—June 19–23; Ophthalmology—July 3–7; 13th Annual General Practice Review—July 17–22; Pediatrics—July 31–August 4; Internal Medicine—August 7–11; Medical Audiology—August 28–September 1; and Hospital Medical Staff Conference—October 2–6.

Allergy Academy Plans Course, Meeting

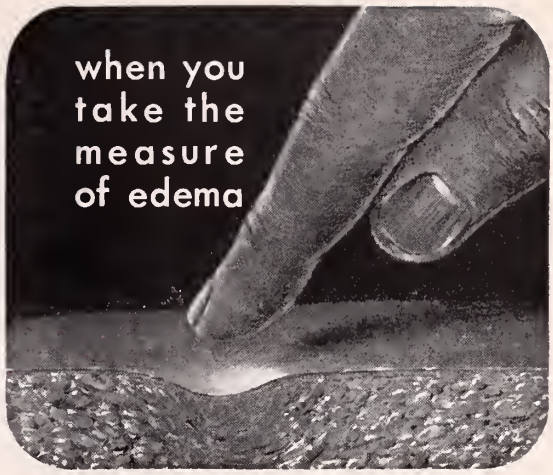
The American Academy of Allergy will present a two-day postgraduate course on "Leukocytes" and "The Autonomic Nervous System" February 18–19, preceding the Academy's 23rd annual meeting February 20–22 in Palm Springs, Calif.

All physicians and persons in related fields are invited to attend the meetings. There is a registration fee for non-members attending the postgraduate course. Students, interns, residents, and fellows will be admitted at no charge, upon presenting proper credentials from their institution when registering. There is no registration fee for the annual meeting scientific sessions.

Additional information can be obtained by writing Executive Office, The American Academy of Allergy, 756 North Milwaukee St., Milwaukee, Wis. 53202.

Laryngology, Bronchoesophagology Course

The department of otolaryngology of the Illinois Eye and Ear Infirmary and the College of Medicine of the University of Illinois at the Medical Center, Chicago, will conduct a postgraduate course in Laryngology and Bronchoesophagology April 10–22.



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Patients with cirrhosis should be observed for impending hepatic coma and hypokalemia. Other reactions may include blood dyscrasias, hyperuricemia and gout, nausea, jaundice, anorexia, vomiting, diarrhea, dizziness, paresthesia, photosensitivity and headache. Hepatic fetor, tremor, confusion and drowsiness are signs of impending pre coma and coma in patients with cirrhosis. Insulin requirements may be altered in diabetes. AQUATAG (benzthiazide) should be used with caution post-operatively as hypokalemia is not uncommon. Potassium supplementation may be advisable pre- and post-operatively. There have been occasional reports of thrombocytopenia, leukopenia, agranulocytosis, aplastic anemia and precipitation of acute pancreatitis or jaundice.

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This course, which is limited to 15 physicians, will be held largely at the Illinois Eye and Ear Infirmary and will include visits to a number of Chicago hospitals. Instruction will be provided by means of animal demonstrations and practice in bronchoscopy and esophagoscopy, diagnostic and surgical clinics, as well as lectures.

Contact Department of Otolaryngology, College of Medicine of the University of Illinois at the Medical Center, P.O. Box 6998, Chicago, Ill. 60680.

UW Course on Mental Retardation

A postgraduate course on "Mental Retardation and Clinical Practice," sponsored by the University of Wisconsin Department of Pediatrics, will be presented April 6–8 at the Wisconsin Center, Madison. Special emphasis will be on the role of the general practitioner and pediatrician in the diagnosis, cure, and treatment of mental retardation.

Speakers and their topics will include Dr. Charles F. Barlow, neurologist, Harvard University, Boston, "Neurological Examination in Mental Retardation;" Dr. Leon Eisenberg, child psychiatrist, Johns Hopkins University, Baltimore, "Child Psychiatry Aspects of Mental Retardation;" Dr. David Y. Y. Hsia, pediatrician, Northwestern University, Chicago, "Inborn Errors of Metabolism and Mental Retardation;" Dr. A. Frederick North, Medical Director, Head Start Program, Washington, D.C., "Progress in Head Start;" Dr. Lionel S. Penrose, Director, Kennedy–Galton Centre, Hertfordshire, England, "Chromosomes and Mental Retardation;" and Dr. George R. Tarjan, child psychiatrist, University of California, San Francisco, "General Considerations in Mental Retardation."

Registrations are now being accepted by the Department of Postgraduate Medicine, University of Wisconsin Medical Center, Madison, and by Harry A. Waisman, M.D., Ph.D., Professor of Pediatrics, University Hospitals, 1300 University Ave., Madison.

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Frontiers of Medicine—Chicago

The University of Chicago Hospitals and Clinics Committee on Continuing Medical Education will present a program on "Deafness and Dizziness—How Do We Stand?" as the fifth in a series on Frontiers in Medicine—1966–1967, on February 8.

For further information: Miss Dorothy Taylor, Office of the Dean, Division of the Biological Sciences, The University of Chicago, Chicago, Ill. 60637. Telephone: MU 4–6100, ext. 5106.

Athletic Injuries Conference, Madison

The second annual postgraduate conference on Prevention and Management of Athletic Injuries will be held on April 12 and 13 at the Wisconsin Center in Madison, sponsored by the University of Wisconsin Medical Center.

The Training and Conditioning of Athletes, The Occurrence and Management of Injuries to the Head and Neck in Football, and the Prevention and Care of Ankle Injuries were the subjects most requested by physicians, trainers, and coaches attending the first annual conference, and they will be featured in this year's program. Dr. Richard Schneider, professor of neurosurgery and Dr. Gerald A. O'Connor, associate professor of orthopedics are coming from the University of Michigan to discuss head and neck injuries and ankle injuries respectively.

An internationally known expert on nutrition from the University of Wisconsin Medical school faculty, Dr. Edgar A. Gordon will discuss The Nutrition of the Athlete. Practical demonstrations of the work in the Training Room and in the Weight Rooms of the University of Wisconsin will be given by Roger Johnson, R.P.T., head athletic trainer of the University and Vernon Woodward, assistant professor of athletics, during the morning session of the conference on Thursday. A panel discussion on reconditioning following injury will conclude the seminar on Thursday afternoon.

The Prevention of Heat Stress in Athletes will be one of the subjects of the opening session on Wednesday afternoon. It will be presented by Dr. Allan J. Ryan, athletic teams physician at the University of Wisconsin.

All physicians interested in the care of athletes and trainers and coaches from Wisconsin and the

surrounding states are invited to attend. For registration or further information, write Coordinator of Postgraduate Medical Education, The Wisconsin Center, 702 Langdon St., Madison, Wis. 53706.

Inflammatory Bowel Disease Seminar

The University of Chicago Hospitals and Clinics Committee on Continuing Medical Education will present another program in its series: Frontiers of Medicine—1966–1967. A seminar on Nature and Management of Inflammatory Bowel Disease will be held March 8 from 2:00 to 4:45 p.m.

Drs. Joseph B. Kirsner and John V. Prohaska are the coordinators. Others on the program include Drs. C. Knight Aldrich and Henry Rappaport.

For further information: Miss Dorothy Taylor, Office of the Dean, Division of the Biological Sciences, The University of Chicago, Chicago, Ill. 60637. Telephone: MU 4–6100, ext. 5106.

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Announcing THE THIRTIETH ANNUAL MEETING OF

THE NEW ORLEANS GRADUATE MEDICAL ASSEMBLY

Conference Headquarters—Roosevelt Hotel—March 6, 7, 8, 9, 1967

GUEST SPEAKERS

John Steinhaus, M. D., Atlanta, Ga.
ANESTHESIOLOGY
H. R. Reichman, M. D., Salt Lake City, Utah
COLON AND RECTAL SURGERY
Rees B. Rees, M. D., San Francisco, Calif.
DERMATOLOGY
Jose M. de la Vega, M. D., Mexico, D. F.
GASTROENTEROLOGY
Nicholas J. Pisacano, M. D., Lexington, Ky.
GENERAL PRACTICE
Gordon W. Douglas, M. D., New York, N. Y.
GYNECOLOGY
Robert C. Hartmann, M. D., Nashville, Tenn.
INTERNAL MEDICINE
C. Thorpe Ray, M. D., Columbia, Mo.
INTERNAL MEDICINE
A. Earl Walker, M. D., Baltimore, Md.
NEUROLOGICAL SURGERY
Humbert L. Riva, M. D., East Orange, N. J.
OBSTETRICS
Arthur H. Keeney, M. D., Philadelphia, Pa.
OPHTHALMOLOGY
Robert W. Bailey, M. D., Ann Arbor, Mich.
ORTHOPEDIC SURGERY
John J. Conley, M. D., New York, N. Y.
OTORHINOLARYNGOLOGY
F. William Sunderman, M. D., Philadelphia, Pa.
PATHOLOGY
Alexander J. Schaffer, M. D., Baltimore, Md.
PEDIATRICS
Henry J. Woloshin, M. D., Philadelphia, Pa.
RADIOLOGY
Curtis P. Artz, M. D., Charleston, S. C.
SURGERY
Richard T. Shackelford, M. D., Baltimore, Md.
SURGERY
John T. Grayhack, M. D., Chicago, Ill.
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This program is acceptable for thirty and one-half (30½) accredited hours by the American Academy of General Practice.

For information concerning the Assembly meeting write Secretary, The New Orleans Graduate Medical Assembly, Room 1528, 1430 Tulane Avenue, New Orleans, Louisiana 70112.

ANNUAL CLINICAL CONFERENCE

CHICAGO MEDICAL SOCIETY

March 5, 6, 7, 8, 1967

Palmer House, Chicago

THIS CONFERENCE WILL BE OF INTEREST TO ALL PHYSICIANS. The program is presented by leaders of medical thought in all fields of medical activity. It is designed to interest the generalist and specialist alike. THE OUTSTANDING LECTURE PROGRAM IS PLANNED TO KEEP US ABREAST OF SCIENTIFIC DEVELOPMENTS IN MEDICINE. In addition certain sessions will take cognizance of happenings in the political and social arena which are molding changes in the practice of medicine. All physicians, regardless of their field of interest, will find this program to be informative and useful.

For program or registration information address:

Clinical Conference Committee
Chicago Medical Society
310 South Michigan Avenue
Chicago, Illinois 60604

WISCONSIN OTOLARYNGOLOGICAL SOCIETY

Scientific Program and Winter Meeting—February 23, 24, and 25

The profession is cordially invited to attend

PROGRAM

Veterans Administration Center, Wood Thursday, February 23

VISITING PROFESSOR: *John R. Lindsay, MD*, Chairman of the Division of Otolaryngology, Department of Surgery, The University of Chicago, Chicago, Ill.

PROGRAM CHAIRMAN: *Roger H. Lehman, MD*, Wood VA Center

HOST FOR DOCTOR LINDSAY: *Meyer S. Fox, MD*, Milwaukee

Milwaukee Children's Hospital

9:30–10:15 AM: Middle Ear Effusions—*Resident and Staff*. Discussion—*Doctor Lindsay*.

10:30–11:15 AM: Congenital and Acquired Deafness in Children—*Doctor Lindsay*.

Veterans Administration Hospital

12:00 N: Luncheon

1:00 PM: Tour of Hospital

1:45–2:30 PM: Otologic Case Presentations—*Residents and Staff*. Discussion—*Doctor Lindsay*.

2:45–3:15 PM: Evaluation of Combined Therapy in Carcinoma of the Laryngopharynx—*Residents and Staff*. Discussion—*Doctor Lindsay*.

University of Wisconsin Medical Center, Madison Friday, February 24

PROGRAM CHAIRMAN: *Maxine Bennett, MD*, Madison

HOST FOR DOCTOR LINDSAY: *Timothy Donovan, MD* and *Albert Olson, MD*, Madison

University Hospitals

8:00–10:00 AM: Grand Rounds (Bradley III)—*James Brandenburg, MD*

11:00–11:50 AM: (Room 300) Junior Medical School Class Lecture, "Dizziness,"—*Doctor Lindsay*. Introduction—*P. A. Sciarra, MD*, President of Wisconsin Otolaryngological Society.

12:15 PM: Luncheon (Hospital Cafeteria). *Residents* and *Doctor Lindsay (Richard Ward, MD)*.

2:00–4:00 PM: Histopathology of Temporal Bone; Study of Microscopic Slides. Demonstration and instruction—*Doctor Lindsay (James Brandenburg, MD)*. (Room 341, Bardeen Lab., Anatomy Dept.) For all otolaryngology residents and other interested physicians and students.

WINTER MEETING—WISCONSIN OTOLARYNGOLOGICAL SOCIETY

University of Wisconsin Medical Center, Madison Saturday, February 25

10:00–10:30 AM: Registration (Lobby, ENT Clinic Bradley II). Coffee.

Morning Scientific Program (Bardeen Room 160)

CHAIRMAN: *P. A. Sciarra, MD*, President

10:30–10:50 AM: Halothane Anesthesia for Tonsillectomy—*E. F. Kronschnabel*, Marquette, Mich. Discussion.

11:00–11:20 AM: Electro-acoustical Characteristics of Hearing Aids—*Donald W. Schaefer*, Madison (by invitation). Discussion.

11:30–11:45 AM: Physiologic and Clinical Evidence for the Neural Origin of Auditory Evoked Potentials—*S. F. Horwitz, MD*, Resident, Milwaukee (by invitation). Discussion.

11:50–12:05 PM: Ameloblastoma; Presentation of Three Cases—*Richard H. Ward, MD*, Resident, Madison (by invitation). Discussion.

12:15 PM: Adjourn for Luncheon

12:30–1:45 PM: Luncheon (wives cordially invited). Ivy Inn, 2355 University Ave., Madison

Afternoon Scientific Program

2:00–3:00 PM: Histopathology of Congenital Deafness and Acquired Viral Infections—*John Lindsay, MD*, Visiting Professor

3:00–4:00 PM: Interesting Case Problems (five minute presentations followed by five minute audience participation).

1. *Lee Eby, MD*, Milwaukee
2. *Richard Ostenso, MD*, Eau Claire
3. *Ben Brindley, MD*, Madison
4. *John Fuller, MD*, Monroe
5. *William Randolph, MD*, Manitowoc

4:00 PM: Business Meeting (members only).

7:30 PM: Basketball (Field House)—University of Wisconsin vs. Michigan State.

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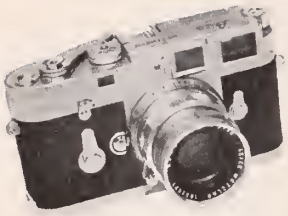

ANNUAL PHOTOGRAPHY CONTEST

MILWAUKEE AUDITORIUM, MILWAUKEE * MAY 9–11, 1967
OPEN TO MEMBERS OF THE STATE MEDICAL SOCIETY

CLASSIFICATIONS

Medicine, Travel, People (at play and at work), Animals, Pictorial (landscape—things —still life, etc.).

ENTRIES

There is no limit to the number of entries allowed to any exhibitor. All entries must be at the State Medical Society headquarters in Madison on or by April 1, 1967.

REQUIREMENTS

(1) All entries must be mounted on white mounting boards 16 x 20 inches only. Boards will be exhibited in vertical position only; (2) Prints may be of any size up to 16 x 20 inches if verticals, 11 x 14 if horizontals; (3) Prints must be placed singly on mounting boards; (4) Entries must carry the following information on the back of the mounting: Title, class entered, name and address of exhibitor. There shall be no writing or printing on the front of the mounting board or on any photo; (5) All photos entered must be taken by the entrant but developing, enlarging and mounting need not be done by him.

AWARDS

Each division, black and white or color, will be judged separately and the following awards given to each classification: First place, second place and third place. In addition, three honorable mention awards will be given to each classification. There will be an award of "Best In Show" given to the best entry, either black and white or color. Trophies will be given to all first place winners and to the "Best In Show" and ribbons for all other awards.

JUDGING

Judging will take place prior to the showing of entries at the Annual Meeting. Winners will be notified of their awards as soon after judging as possible.

MAIL TODAY

PHOTO CONTEST ENTRY

Mail to State Medical Society of Wisconsin, P. O. Box 1109, Madison, Wis. 53701
BEFORE YOU SUBMIT YOUR ENTRY.

All entries must be submitted before April 1, 1967.

Name _____

Address _____

	BLACK & WHITE	COLOR	TOTAL
Medicine	_____	_____	_____
Travel	_____	_____	_____
People	_____	_____	_____
Animals	_____	_____	_____
Pictorial	_____	_____	_____

A Special Annual Meeting Feature

MEDICAL ART SALON

SPONSOR: The Woman's Auxiliary to the State Medical Society of Wisconsin

CO-CHAIRMEN: Dr. and Mrs. Reuben Snartemo, and Dr. and Mrs. Harry Watson, Jr., Milwaukee

MILWAUKEE AUDITORIUM . . . MAY 9–11, 1967

Sculptures and Paintings (watercolors and oils only)

WHO MAY EXHIBIT: Any member of the State Medical Society of Wisconsin or his wife.

LIMITED ENTRIES: Up to 3 entries per person.

DEADLINE FOR ENTRIES: All notifications of "Intent to Exhibit" must be in the hands of Dr. and Mrs. Reuben Snartemo, Milwaukee, on or before April 1, 1967. (Early notification will be appreciated, so that proper facilities for the entire exhibit can be planned in advance. Mail your entry blank below as soon as possible.)

REQUIREMENTS: (1) All pictures must be framed with wire and screw eyes attached. (2) Works of sculpture must not exceed 24 inches in height. (3) All entries must be delivered to the Dressing Room on the east side of the stage of Bruce Hall, Milwauwkee Auditorium between 8:00 a.m. and 10:00 a.m., Monday, May 8, and must be picked up in the display area between 3:30 p.m. and 5:00 p.m., Thursday, May 11.

JUDGING AND AWARDS: Ribbons for first, second, and third places in each of the three categories (sculpture, watercolor painting, oil painting) will be awarded, plus a "popularity award" based on votes of all those who view the Art Salon.

LIMITED LIABILITY: The submitter must assume full responsibility for work submitted, but every care against damage or theft will be exercised. Guard will be provided during the course of the display.

NOTIFICATION OF INTENT TO EXHIBIT

Mail to Dr. and Mrs. Reuben Snartemo, 5529 W. Jackson Park Drive, Milwaukee, Wis. 53219, BEFORE APRIL 1, 1967.

I plan to submit the following entry or entries for the 1967 MEDICAL ART SALON at the Milwaukee Auditorium, May 9–11.

My entry, or entries, will be:

(1) Painting ____ Title _____ ☐ watercolor ☐ oil size _____" wide and _____" deep

(2) Painting ____ Title _____ ☐ watercolor ☐ oil size _____" wide and _____" deep

(3) Painting ____ Title _____ ☐ watercolor ☐ oil size _____" wide and _____" deep

(1) Sculpture __ Title _____ size _____" wide and _____" high

(2) Sculpture __ Title _____ size _____" wide and _____" high

(3) Sculpture __ Title _____ size _____" wide and _____" high

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MEDICAL MEETINGS

POSTGRADUATE COURSES

1967 WISCONSIN

Mar. 6–17: Advanced maternity program in delivery room nursing, Marquette University College of Nursing, Milwaukee.

Mar. 9: "In Depth" program on "Cardiac Emergencies and Intensive Care," sponsored by the State Medical Society's CES Foundation, presented by the University of Wisconsin Medical School, Madison.

Mar. 11–12: Council Meeting, State Medical Society, Madison.

Mar. 30–31: Annual meeting, Wisconsin Anti-Tuberculosis Association, Milwaukee.

Apr. 6–8: Postgraduate conference on "The Mentally Retarded Child," sponsored by the Department of Pediatrics, University of Wisconsin.

Apr. 10–21: Advanced maternity program in delivery room nursing, Marquette University College of Nursing, Milwaukee.

Apr. 12–13: Second annual postgraduate conference on prevention and management of athletic injuries, sponsored by University of Wisconsin Medical Center, Wisconsin Center building, Madison.

May 9–11: State Medical Society annual meeting, Milwaukee.

May 20: Annual meeting, Wisconsin Heart Association, Milwaukee.

Aug. 24–26: Conference on "Current Concepts in Surgery" sponsored by the Department of Surgery, UW Medical Center, at Wisconsin Center, Madison.

Sept. 14: Symposium on stroke, sponsored by the Wisconsin Heart Association and the Adolf Gundersen Medical Foundation, La Crosse.

Oct. 16–20: Wisconsin Work Week of Health, State Medical Society of Wisconsin, Madison.

1967 NEIGHBORING STATES

Mar. 8: "Nature and Management of Inflammatory Bowel Disease," sixth in a series of programs by the University of Chicago Hospitals and Clinics.

Mar. 13–17: Postgraduate course in proctology, University of Minnesota, Minneapolis.

Mar. 20–24: Postgraduate course in "Fundamental Concepts of Gastroenterology," sponsored by the American College of Physicians, at the University of Michigan, Ann Arbor.

Mar. 20–24: American College of Physicians postgraduate course, "Fundamental Concepts of Gastroenterology," University of Michigan Medical Center, Ann Arbor.

Mar. 27–31: American College of Physicians postgraduate course, "Psychiatry for the Internist," Wayne State University School of Medicine, Detroit.

Mar. 27–31: Postgraduate course in "Psychiatry for the Internist," sponsored by the American College of Physicians, at Wayne State University, Detroit, Mich.

Apr. 7–8: Postgraduate course in trauma, University of Minnesota, Minneapolis.

Apr. 10–22: Postgraduate course in laryngology and bronchoesophagology, Illinois Eye and Ear Infirmary, Chicago.

Apr. 12: "Endocrines and the Reproductive System," seventh in a series of programs by the University of Chicago Hospitals and Clinics.

Apr. 19–22: 11th Annual Postgraduate Course on Fractures and Other Trauma, sponsored by American College of Surgeons, John B. Murphy Auditorium, Chicago.

Apr. 27–29: Postgraduate course in obstetrics, University of Minnesota, Minneapolis.

May 1–3: Postgraduate course in ophthalmology, University of Minnesota, Minneapolis.

May 10: "Head Injuries," eighth in a series of programs by the University of Chicago Hospitals and Clinics.

May 11–13: Fourth Midwest Anesthesiology Conference, sponsored by Illinois Society of Anesthesiologists, The Palmer House, Chicago, Ill.

May 25–27: Postgraduate course in surgery, University of Minnesota, Minneapolis.

June 1–3: Postgraduate course in anesthesiology, University of Minnesota, Minneapolis.

June 12–15: Catholic Hospital Association convention, Chicago.

June 19–21: Postgraduate course in "Clinical Applications—Recent Advances in Pharmacology," presented by the American College of Physicians, at the University of Iowa, Iowa City.

Oct. 2–6: Annual clinical congress, American College of Surgeons, Chicago.

1967 OTHERS

Mar. 6–9: 30th annual New Orleans Graduate Medical Assembly, New Orleans, La.

May 3: Scientific session, American Cancer Society, Dallas, Tex.

June 25–July 2: Fifth International Congress of Chemotherapy, Vienna.

June 26–28: Spring Clinics, Children's Hospital, Denver.

July 2–6: European Cancer Meeting, Vienna.

1968 OTHERS

Oct. 21–25: Annual Clinical Congress, American College of Surgeons, Atlantic City, N.J.

For listing of other meetings see the JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION.

Mental Retardation Course at Madison

A postgraduae course in "Mental Retardation and Clinical Practice" will be given April 6–8 at the Wisconsin Center, sponsored by the Department of Pediatrics, University of Wisconsin Medical Center.

Special emphasis will be on the role of the general practitioner and pediatrician in the diagnosis, cure, and treatment of mental retardation. Several outstanding speakers will be present for the three-day conference and these include: Dr. Charles F. Barlow, neurologist, Harvard University, Boston, who will speak on "Neurological Examination in Mental Retardation;" Dr. Leon Eisenberg, child psychiatrist, Johns Hopkins University, Baltimore, who will speak on "Child Psychiatry Aspects of Mental Retardation;" Dr. David Y. Y. Hsia, pediatrician, Northwestern University, Chicago, "Inborn Errors of Metabolism and Mental Retardation;" Dr. A. Frederick North, medical director, Head Start Program, Washington, D. C., "Progress in Head Start;" Dr. Lionel S. Penrose, director, Kennedy–Galton Centre, Hertfordshire, England, "Chromosomes and Mental Retardation;" and Dr. George A. Tarjan, child psychiatrist, University of California at San Francisco, "General Considerations in Mental Retardation."

Registrations are now being accepted by the Department of Postgraduate Medicine, University of Wisconsin Medical Center, and by Harry A. Wais-

man, MD., Ph.D., Prof. of Pediatrics, University Hospitals, 1300 University Ave., Madison, Wis. 53706.

Current Concepts in Surgery, Madison

The Department of Surgery of the University of Wisconsin Medical Center will present a conference on "Current Concepts in Surgery" August 24–26 at the Wisconsin Center on the university campus in Madison.

The conference, stressing contemporary surgical thought, will feature nationally prominent speakers as well as faculty members of the University of Wisconsin Medical Center. Robert C. Hickey, M.D., Professor and Chairman, Department of Surgery, is the conference chairman. Luxury dormitory facilities will be available for participants and their families during the conference.

For further information contact Thomas C. Meyer, M.D., Assistant Dean, Department of Postgraduate Medical Education, Room 302, 333 North Randall Avenue, Madison, Wis. 53706.

European Cancer Meeting

The Fifth International Congress of Chemotherapy will meet June 25 to July 2 in Vienna, followed by a European Cancer Meeting, July 2 to July 6. For details contact the Vienna Academy of Medicine, Stadiongasse 6–8, A-1010, Vienna.

Clinics at Children's Hospital, Denver

Children's Hospital, Denver, is holding its Spring Clinics at Vail on June 26, 27, 28. Guest Faculty: Sydney Gellis, M.D., Tufts University; Mary Ellen Avery, M.D., Johns Hopkins University; Robert Kugel, M.D., University of Nebraska; James K. Weaver, M.D., University of New Mexico; William Daeschner, M.D., University of Texas; Hugh Thompson, M.D., Tucson, District Chairman of Region VIII of the Academy of Pediatrics. Morning seminars and lectures. Afternoons of leisure in the Rocky Mountains. Advances in Pediatrics and The Path Ahead in Pediatric Practice will be the guidelines for the Clinics.

Fee $40.00. Write: Joseph Butterfield, M.D., Children's Hospital, Nineteenth Avenue at Downing, Denver, Colo. 80218.

Medical Assistants Society, Milwaukee

The Milwaukee County Medical Assistants will hold their regular monthly meeting March 16 at 7:45 pm at the Women's Clubs Clubhouse, 1462 N. Prospect Avenue. A workshop will be led by several members of the group and all medical assistants are invited.

On April 20, at 7:30 pm, the meeting will be at St. Joseph's Hospital, 5000 W. Chambers Street where Benjamin Louthan, M.D. will speak on "Anesthesia Yesterday and Today." A tour will also take place.

Anesthesiology Conference, Chicago

The Fourth Midwest Anesthesiology Conference, sponsored by the Illinois Society of Anesthesiologists, will be held at The Palmer House, Chicago, May 11, 12, 13. The scientific program is entitled "Physiologic Measurements in Clinical Anesthesia." For details, contact Anna E. Barnstable, M.D., 301 Oak Tree Lane, Waukegan, Ill. 60089.

American Academy of Pediatrics Meeting

More than 3,000 pediatricians, their families and guests, will attend the American Academy of Pediatrics' annual spring session, April 3–5 in San Francisco.

The meeting, to be held in the new San Francisco Hilton Hotel, will feature closed-circuit television clinical presentations, a diversified scientific program, and more than 120 scientific and technical exhibits.

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The scientific program will examine six major areas. These will include child health in contemporary American society, the newborn, neurologic disorders in children, the child from two to six, school difficulties: childhood's chief occupational hazard and adolescent growth and behavior.

Television presentations will be beamed directly from the Presbyterian Medical Center to the San Francisco Hilton Hotel.

Televised subjects will include brain tumors, dermatologic disease in the young child, the eye examination, oral biology, and venomous animal injuries.

Also, the Academy and the California Nurses Association will cosponsor a conference for nurses in child health, April 3–4 in the St. Francis Hotel.

Course on Fractures and Other Trauma, Chicago

The Chicago Committee on Trauma of the American College of Surgeons is sponsoring its Eleventh Postgraduate Course on Fractures and Other Trauma, April 19–22. It will be held in the John B. Murphy Auditorium at 50 East Erie Street, Chicago, Ill.

Although orthopaedic aspects of trauma will comprise most of the presentations, abdominal, thoracic, neurological, genitourinary, vascular, and plastic problems will be covered. Basic material concerning the nature and treatment of shock will be discussed. Plans are being made to have panel discussions concerning the management of athletic injuries, and the management of patients with multiple injuries. An evening session of case presentations by the staff at the U.S. Naval Hospital, Great Lakes, Ill., will cover military injuries.

The faculty will be comprised of members of the faculties of the medical schools in Chicago, as well as several visiting authorities. Dr. Martin P. Sayers, Clinical Associate Professor of Neurosurgery, Ohio State University will present several talks on neurological injuries. Dr. Don R. O'Donoghue, Professor and Chairman of the Department of Orthopaedic Surgery and Fractures, University of Oklahoma Medical School, and Past President of the American Orthopaedic Association, will speak on athletic injuries with particular attention to those concern-

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ing the knee. Dr. Anthony F. DePalma, Professor of Orthopaedic Surgery, Jefferson Medical College, Philadelphia, Pennsylvania, and Editor-in-Chief, Emeritus, *Clinical Orthopaedics and Related Research*, will speak on shoulder and cervical spine problems.

The tuition, which is $80.00, includes the Chairman's reception on the evening of April 19, and luncheon at the Kungsholm Restaurant on one of the meeting days. Registration can be accomplished by writing to James P. Ahstrom, Jr., M.D., Chairman, Eleventh Postgraduate Course, American College of Surgeons, 55 East Erie Street, Chicago, Illinois 60611. Reservations at one of the many nearby hotels should be made individually and separately.

ACP Gastroenterology Course for Internists

The American College of Physicians (ACP) will sponsor a five-day postgraduate course March 20–24 on "Fundamental Concepts of Gastroenterology" in Ann Arbor, Mich.

The course will be given at the University of Michigan Medical School. It is one of 20 postgraduate courses being held throughout the United States during the current academic year.

The ACP course has been designed to help keep practicing internists abreast of new knowledge in the biochemical and physiologic causes of diseases of the stomach and intestinal tract. Biochemical aspects of absorption and nutrition, clinical implications of enzyme levels and immunologic mechanisms involved in these diseases will be discussed.

H. Marvin Pollard, M.D., Ann Arbor, Mich., Professor of Internal Medicine at the University of Michigan Medical School, is course director.

Faculty will be drawn from the university, with guest lecturers from the University of California, University of Minnesota, Albert Einstein College of Medicine, the Mayo Clinic and other institutions. Charlotte M. Anderson, M.D., head of the Gastroenterological Research Unit, Royal Children's Hospital, Melbourne, Australia, has been invited as a guest lecturer.

For information and registration, write Edward C. Rosenow, Jr., M.D., Executive Director, American College of Physicians, 4200 Pine St., Philadelphia, Pa. 19104.

SMS Annual Meeting

The 1967 State Medical Society Annual Meeting will be held May 9–11 in Milwaukee. A condensed program appears in this issue at pp. 71–76.

ANNUAL CLINICAL CONFERENCE

CHICAGO MEDICAL SOCIETY

March 5, 6, 7, 8, 1967

Palmer House, Chicago

THIS CONFERENCE WILL BE OF INTEREST TO ALL PHYSICIANS. The program is presented by leaders of medical thought in all fields of medical activity. It is designed to interest the generalist and specialist alike. THE OUTSTANDING LECTURE PROGRAM IS PLANNED TO KEEP US ABREAST OF SCIENTIFIC DEVELOPMENTS IN MEDICINE. In addition certain sessions will take cognizance of happenings in the political and social arena which are molding changes in the practice of medicine. All physicians, regardless of their field of interest, will find this program to be informative and useful.

For program or registration information address:

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Chicago Medical Society
310 South Michigan Avenue
Chicago, Illinois 60604

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References: 1. Pillsbury, D. M., Shelley, W. B., and Kligman, A. M.: A manual of cutaneous medicine, Philadelphia, Saunders, 1961, p. 79. **2.** Barber, M., and Garrod, L. P.: Antibiotic and chemotherapy, Baltimore, Williams and Wilkins, 1963, p. 111.

COUNTY SOCIETY PROCEEDINGS

ASHLAND, BAYFIELD, IRON

Dr. John Wolfe, Duluth plastic surgeon, was guest speaker in December of the Ashland, Bayfield and Iron County Medical Society, in Ashland.

Dr. Harold Guzzo was elected president of the three-county society. Other officers are *Dr. Joseph M. Jauquet*, president-elect; *Dr. Clifford A. Grand*, secretary and treasurer; and *Dr. William A. Bargholtz*, delegate to the State Medical Society.

BROWN

President-elect of the Brown County Medical society is *Dr. Leonard Miller. Dr. Kenneth Mickle* was chosen secretary-treasurer and *Dr. Robert Johnston*, censor. Delegates to the state society are *Drs. Donel Sullivan* and *Joseph Grace. Drs. Henry Rahr* and *Lyle Edelblute* will serve as alternates. *Dr. Charles Wunsch* is president of the Society.

CLARK

In memory of Dr. Meric V. Overman of Neillsville, who died Dec. 17, 1966, the Clark County Medical Society has decided to donate $100 to the Charitable, Educational and Scientific Foundation of the State Medical Society of Wisconsin for medical student loans.

DANE

Dr. Charles Hopkins spoke on his medical experiences in Vietnam at the December meeting of the Dane County Medical Society. Two physicians admitted to membership at this meeting were *Dr. Ivan D. Knezevic* and *Dr. Stanley Miezio, Jr.*

Guest speaker at the February 14 meeting of the Dane County Medical Society in Madison was *Dr. James W. Nellen*, Green Bay, team physician for the Green Bay Packers.

New members of the Society are *Dr. Zorislav Greblo*, a Yugoslavian, who is now practicing at Mendota State Hospital, Madison; and *Dr. Timothy T. Flaherty* of Fond du Lac who is an instructor in the Department of Radiology, University of Wisconsin Medical Center.

FOND DU LAC

A Ripon doctor has been selected to head the Fond du Lac County Medical Society. *Dr. Russell S. Pelton* will head the group this year. The Society will celebrate its 100th anniversary in 1968.

Physicians whose names appear in italics are members of the State Medical Society.

GRANT

The annual immunization program, sponsored by the Grant County Medical Society and the County Health Committee, began February 6 and included immunization for diphtheria, whooping cough, and tetanus, and smallpox vaccination.

JEFFERSON

Dr. Robert G. Handeyside, Fort Atkinson, was elected president of the Jefferson County Medical Society at its December meeting. Other new officers are: *Dr. R. R. Liebenow*, Lake Mills, vice-president; *Dr. Stanley F. Vognar*, Fort Atkinson, secretary-treasurer. Delegate to the State Medical Society is *Dr. M. G. Peterson*, Lake Mills, and alternate delegate Doctor Liebenow.

The Jefferson County group recently donated arship fund available to Jefferson County nursing students or medical technicians.
$8,000 to the Charitable, Educational and Scientific Foundation of the State Medical Society as a schol-

KENOSHA

Dr. W. C. Rattan has been elected president of the Kenosha County Medical Society for 1967. Other officers include *Dr. M. J. Bode*, president-elect; *Dr. J. T. Duncan, Jr.*, past president; and *Dr. Fredrick Wood, Jr.*, secretary-treasurer. *Drs. Louis Olsman* and *Morris Siegel* are SMS delegates; *Drs. G. F. Armstrong* and *F. C. Williams*, alternate delegates.

LINCOLN

The Lincoln County Medical Society participated in sponsoring December and January visits of the State Board of Health Mobile Survey Unit in Merrill. Screening tests for diseases of the heart and lungs, high blood pressure, and diabetes were conducted.

MILWAUKEE

Dr. George E. Collentine, Jr., surgeon, has been named president-elect of The Medical Society of Milwaukee County. Currently director of the Burn Center at St. Mary's Hospital, he is also assistant clinical professor of surgery at Marquette University School of Medicine. He was chief of surgery at St. Mary's from 1956 to 1964. A graduate of the Marquette University School of Medicine, Doctor Collentine also holds a master of science degree in surgery from the University of Pennsylvania.

Dr. Collentine has been active in medical society activities since 1951. He has served on the group's committees on blood and blood substitutes, cancer, scientific research, public relations, public policy, and postgraduate education. Since 1956 he has been a delegate to the State Medical Society and also an alternate delegate to the American Medical Association.

Other officers elected by the Milwaukee Society were *Drs. William L. Coffey, Jr.*, secretary, and *Joseph L. Mueller*, treasurer.

A certificate of merit was awarded to *Dr. Tibor J. Greenwalt*, medical director of the Milwaukee Blood Center, for his "vigorous and decisive leadership" in that post since 1946. Doctor Greenwalt has resigned to become medical director of the American Red Cross blood program in Washington, D. C.

Dr. Christopher R. Dix, plastic surgeon, is currently president of the County Society.

Dr. James D. Hardy, professor and chairman of the Department of Surgery at the University of Mississippi spoke on "The Replacement of Organs—Status and Prospects," at the January meeting of The Medical Society of Milwaukee County. He also served as Carl Eberbach Visiting Professor of Surgery at Marquette University School of Medicine during his stay.

The March guest speaker before the Medical Society will be Dr. Marvin A. Block, former chairman of the American Medical Association's Committee on Alcoholism. Doctor Block, an assistant professor of clinical medicine at the State University of New York at Buffalo, will speak on "Approaching the Problem of Alcoholism" at the March 9 meeting in the Milwaukee Athletic Club.

OUTAGAMIE

The Outagamie County Medical Society has appointed *Dr. Thomas M. Loescher* as medical representative on the county board's health, education and institutions committee. A general practitioner in Appleton, Doctor Loescher is also serving as advisor to the county nurse, and as coordinator between the society and the county group.

RACINE

Dr. William J. Madden has been installed as president of the Racine County Medical Society. Other officers are *Dr. Arthur Jacobsen*, president-elect; *Dr. Elizabeth A. Steffen*, secretary, and *Dr. James J. G. Petersen*, treasurer. Elected to the executive committee were *Drs. William Harris* and *Marvin Nelson*.

RICHLAND

Dr. Robert Green, La Crosse and *Dr. William Ylitalo*, Madison, gave a combined talk on "Rheumatic Heart Disease and Cardiac Murmurs" at a recent meeting of the Richland County Medical Society.

TREMPEALEAU–JACKSON–BUFFALO

A program on mental health highlighted the January 24 meeting of the Tri-County Medical Society at Black River Falls.

WAUKESHA

"Regional Medical Centers and the Practicing Physician" was the subject of a talk by *Dr. Gerald Kerrigan*, dean of Marquette University School of Medicine, before a recent meeting of the Waukesha County Medical Society. New members admitted to the Society at this meeting were *Drs. William M. Brennan, Henry D. Drayer, Som D. Varma*, and *Robert S. Viel*.

The January 4 meeting of the Society was held at the Merrill Hills Country Club where the group heard a discussion on "State Rehabilitation Practices, Objectives, and Facilities in the Waukesha Area."

Dr. Ross Kory of Veterans Administration Hospital, Wood, spoke on the relationship between the hospital and practicing physicians at a recent meeting of the Waukesha County Medical Society.

The Waukesha County Medical Society recently passed a resolution granting a "vote of thanks" to *Dr. Ruth Church*, former county medical director. Doctor Church retired January 1 after serving as director since the department was organized 5½ years ago.

WINNEBAGO

Featured speaker at the January meeting of the Winnebago County Medical Society was *Dr. William Hildebrand*, Menasha, who spoke on "Highlights of the Interim Session of the American Medical Association in Las Vegas, Nev."

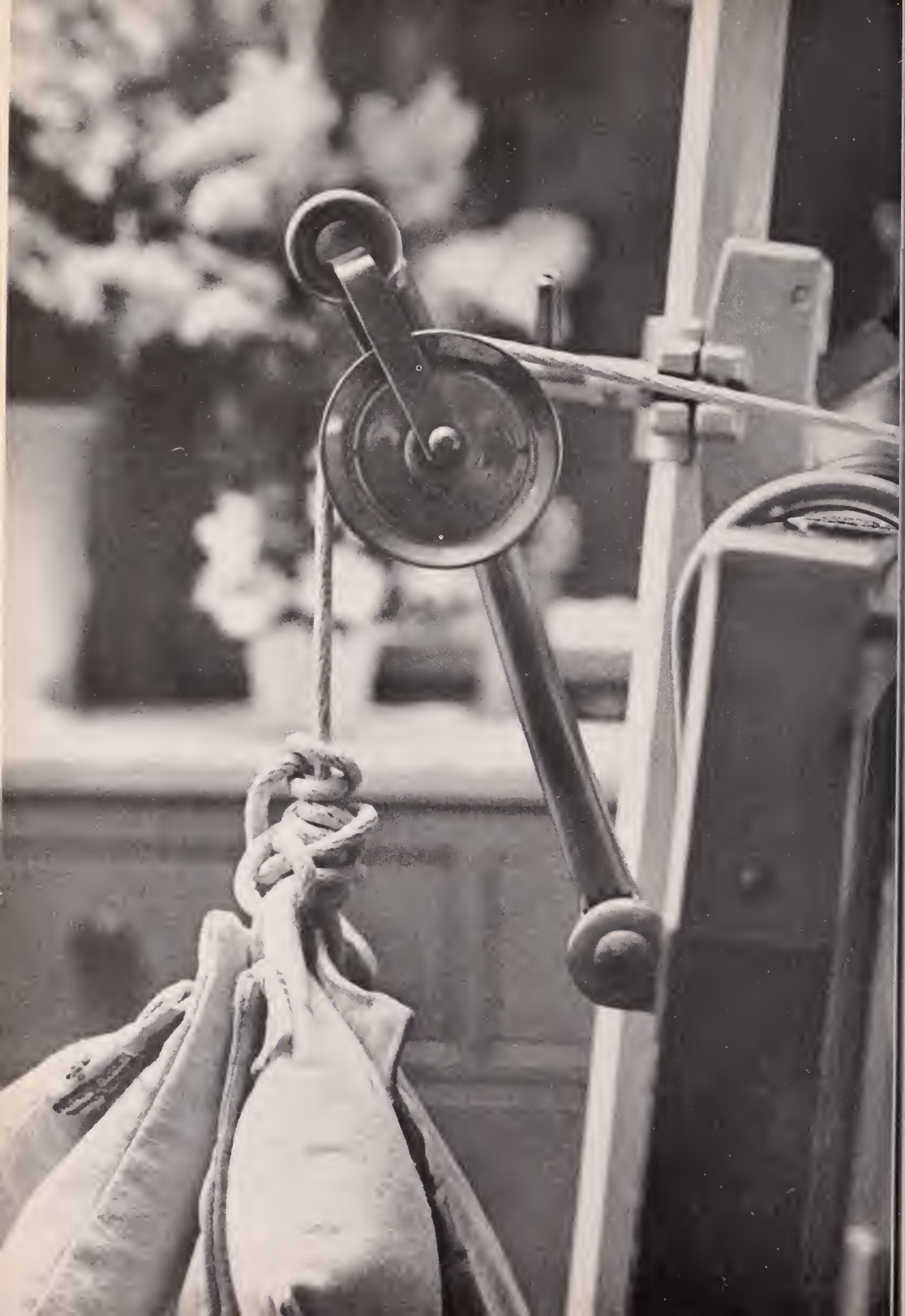
Dr. Paul Natvig of Milwaukee spoke on oral cancer at the February meeting of the Society.

WOOD

Otto Richter, of the State Board of Vocational Rehabilitation, spoke on the board's work with the handicapped at a recent meeting of the Wood County Medical Society in Marshfield.

"The role played by the county medical society in winning public confidence and respect for the medical profession by service to the community has long been a keystone of organized medicine. It is here, at this local level, that medical service programs rise or fall and public opinion is gained or lost. Therefore, it must follow that the activities sponsored or promoted by our county medical society are very important to us as physicians and to the public which we serve."

—DR. ROBERT J. ALBI, president of the Spokane (Wash.) County Medical Society, in its bulletin, September 1966



SPECIALTY SOCIETY PROCEEDINGS

Hear Transplantation Advances

"Recent Advances in Corneal Transplantation" was the subject of a talk at the January meeting of the Milwaukee Oto-Ophthalmology Society. Guest speaker was Dr. William Hughes of Presbyterian Hospital, Chicago.

Otolaryngological Society Meets

Dr. John R. Lindsay, chairman of the Division of Otolaryngology, Department of Surgery, at the University of Chicago, was the visiting professor invited to speak at the Wisconsin Otolaryngological Society's winter meeting February 23 to 25.

The program was held in two locales: the opening day's discussion at the Veterans Administration Center, Wood; followed by two days at the University of Wisconsin Medical Center in Madison. Program chairmen for the three days were *Drs. Roger H. Lehman,* Wood, *Maxine Bennett,* Madison, and *P. A. Sciarra,* Sheboygan.

Officers of the Wisconsin group for the current year are Doctor Sciarra, president; *Dr. Frank G. Treskow,* Milwaukee, vice-president; and Doctor Bennett, secretary and treasurer.

Ophthalmologists Hear Dr. Thygeson

State ophthalmologists heard Dr. Phillips Thygeson give the first Haessler Memorial Lecture to the Milwaukee Ophthalmological Society recently.

Doctor Thygeson, a leading expert on external diseases of the eye, spoke on "Ocular Hypersensitivity Diseases." He is director of the Francis I. Proctor Foundation for Research in Ophthalmology and professor of ophthalmology at the University of California in San Francisco. While in Milwaukee he also spoke at clinical conferences at Marquette University School of Medicine, County General Hospital, and the Veterans Administration Hospital, Wood.

The Haessler Memorial Lecture has been established by the Medical Society of Milwaukee County in memory of Dr. F. Herbert Haessler, late professor of ophthalmology at Marquette.

Dr. McKusick Guest of Milwaukee Academy

Dr. Victor A. McKusick, professor of medicine at Johns Hopkins University School of Medicine, was the visiting professor at a three-day meeting of the Milwaukee Academy of Medicine. His main lecture was "Heritable Disorders of Connective Tissue, Newer Aspects," at the University Club. He also spoke at Columbia, Milwaukee County General, Milwaukee Children's, and Veterans Administration hospitals.

Milwaukee Branch Officers

Dr. Morris Gelfman, Milwaukee, is the new president-elect of the Milwaukee Branch of the Wisconsin Psychiatric Association. Others are *Dr. Samuel Black,* Milwaukee, president; *Dr. Morton Josephson,* Wauwatosa, secretary, and Dr. William J. Crowley, Wauwatosa, treasurer.

Dr. Raymond Headlee, Wauwatosa, addressed the November meeting of the group on "The Case Against Psychiatry." His talk involved a discussion of the community's false concepts concerning psychiatrists and factors necessary to combat them.

Milwaukee Academy Hosts Dr. Beecher

Dr. Henry K. Beecher, Dorr Professor of Anesthesia at Harvard Medical School, was a recent speaker at a meeting of the Milwaukee Academy of Medicine at the University Club of Milwaukee.

Milwaukee Psychiatrists Meet

Dean Roe, administrator of the Milwaukee Psychiatric Hospital, recently addressed a meeting of the Milwaukee Branch of the Wisconsin Psychiatric Association. He discussed results of a survey on Milwaukee area hospital psychiatric facilities.

Milwaukee Academy of Medicine Officers

The Annual Meeting of the Milwaukee Academy of Medicine was held at the University Club January 17 at which time the following officers were elected: president, *Dr. Robert A. Frisch;* president-elect, *Dr. E. A. Bachhuber;* vice-president, *Dr. Bruno J. Peters;* secretary, *Dr. Paul G. LaBissoniere;* treasurer, *Dr. Walton D. Thomas;* librarian, *Dr. Richard D. Fritz;* and chairman of the membership committee, *Dr. Glenn H. Franke. Dr. David J. Carlson* was elected to serve a four-year term on the membership committee.

A special feature of this meeting was the presence of Dr. Charles L. Hudson, president of the American Medical Association, who spoke on "The Physician in Society."

WAGP Mt. Telemark Symposium

The Fourth Annual Lilly Symposium and Ski Outing presented by the Indianhead Chapter of the Wisconsin Academy of General Practice, was held February 14–16 at Mt. Telemark, Cable. A faculty from the Mayo Clinic, Rochester, Minn., presented the three-day scientific program on general medical and surgical subjects. The faculty included Dr. James K. Masson, plastic surgeon; Dr. James C. Broadbent, cardiologist; Dr. David E. Dines, chest physician; and Dr. H. A. Peterson, orthopedic surgeon.

Physicians whose names appear in italics are members of the State Medical Society.

Students Hear Panel on Cancer

Five Walworth county physicians presented a panel discussion recently to Walworth area students on the correlation between cancer and smoking. The program, sponsored by the American Cancer Society, featured *Drs. Irwin Bruhn*, Walworth; Joseph Schrock, Jr., Sharon; Roger Peterson, Elkhorn; *Glenn Smiley*, Delavan; and *Steven Ambrose*, Whitewater.

Yale Professor Talks on Cancer

Dr. Alvan R. Feinstein, an associate professor of medicine at Yale University, gave lectures on cancer in both Milwaukee and Madison recently. The lectures were part of the Dearholt Days talks sponsored by the Wisconsin Anti-Tuberculosis Association. The first lecture was given at the Milwaukee County General Hospital and the second at the University of Wisconsin Medical School.

Watertown Immunization Clinic

—Photo courtesy WATERTOWN DAILY TIMES

Smiling bravely (for the moment), 16-months old Jill Ellen Schmitz submits to o measles vaccinotion at a recently-held Wotertown immunization clinic. The voccine is administered by Dr. Ruth Schuh, city health officer, while Jill is held by her grandmother, Mrs. Gerhardt Schmitz. The clinic was arranged by the Watertown Jaycees, the Joycettes, and the Watertown Health Department.

"Hearts and Husbands" Forum

Heart disease was the subject of a recent public forum in Sheboygan, sponsored jointly by the Sheboygan Kiwanis Club and the Sheboygan County unit of the Wisconsin Heart Association. Called "Hearts and Husbands" three heart specialists discussed the significant factors in heart problems. They were *Drs. Robert M. Senty* and *H. J. Winsauer*, Sheboygan, and *Dr. H. J. McLane*, Fond du Lac.

Posthumous Award to Dr. Smiles

The Ashland County Heart Association recently awarded a posthumous plaque to the late Dr. William J. Smiles of Ashland. It was accepted by his widow and presented by William Chase, Ashland County Heart Association chairman. Also present was Earle Welch, Eau Claire, director of the Northwest Wisconsin Heart Association.

Physicians whose names appear in italics are members of the State Medical Society.

PARAMEDICAL ANCILLARY GROUPS

Medical Administrators Honor Rank

Robert C. Rank, recently named administrative assistant to Sister Mary Daniel, O.S.F., R.N., at Holy Family Hospital, Manitowoc, has been elected a nominee of the American Academy of Medical Administrators. The honor was announced at a recent meeting of the group in Boston. Mr. Rank was certified for proficiency in the basic sciences by the states of Florida, Wisconsin, and Iowa. He had previously been cited by Gov. Harold Hughes of Iowa for his work in teaching medical self help.

Dane County Mental Health Meets

Proposals for comprehensive mental health and mental retardation services were discussed at the recent annual meeting of the Dane County Mental Health Center. Main focus was on how the county might qualify for federal funds to partially aid the building of a mental health center to serve alcoholics as well as the mentally ill and retarded.

Alcohol Seminar at Janesville

A Rock County Seminar on Alcoholism was held recently at Mercy Hospital, Janesville. The Rock County Mental Health Association was instrumental in bringing together various agencies and individuals in the county whose work in some way involved aid to the alcoholic.

Dr. Morris Heads West Central Group

Dr. David Morris, West Salem, is the new president of the six-county West Central Wisconsin Mental Health Center, Inc. He will head a 22-member board responsible for planning and coordinating mental health services in La Crosse, Monroe, Vernon, Buffalo, Jackson and Trempealeau counties.

Smoking Versus Cancer Panel

The Green County Unit of the American Cancer Society sponsored a recent panel for teen-agers at The Monroe Clinic. The panel included *Dr. Arthur Chandler, Jr.*, radiologist at the clinic; *Dr. William Maddix*, internist, and *Dr. Eugene Eckstam*, thoracic surgeon.

PARAMEDICAL/ANCILLARY GROUPS

continued

Wisconsin Council of Safety Conference

—Photo courtesy STATE BOARD OF HEALTH

Among those oddressing sessions of the Wisconsin Council of Sofety Midwinter Safety Conference ond Exposition at Milwoukee Jonuory 19–20 were (left to right) Miss Elizabeth Schneider, RN, of Gilbert Poper Co., Menasha, who is choirmon of the occupotionol health section executive committee; Dr. O. Todd Mollery, Jr., medicol director, Employers Insurance of Wousou, ond Dr. George H. Handy, octing ossistont stote heolth officer.

—Photo courtesy STATE BOARD OF HEALTH

Miss Hozel Stover, RN, of Luther Hospitol, Eou Claire, (right) discusses o new directive for Wisconsin occupotional nurses with Mrs. Shirley Ann Fessler, RN, The Monitowoc Co., Monitowoc (left) ond Miss Elizabeth Schneider, RN, Gilbert Paper Co., Menasho, ot o session of the Wisconsin Council of Sofety Midwinter Sofety Conference ond Exposition ot Milwoukee Jonuory 19–20. The directive manuol, produced by the Wisconsin Nurses Associotion, Stote Medical Society of Wisconsin, ond the State Board of Heolth, wos presented ot o session of the safety conference occupational heolth section.

Dr. Conley Heads Cancer Group

Dr. J. E. Conley was reelected president of the Milwaukee Division of the American Cancer Society at the recent annual meeting in Milwaukee. *Dr. L. J. Van Hecke* was reelected vice-president of the division and both physicians were named to the board of directors and to the executive committee. Others reelected were *Dr. E. H. Ellison* to the board of directors and *Drs. D. J. Carlson* and *R. S. Cron* to the executive committee. Doctor Ellison was also appointed vice-chairman of the American College of Surgeons Committee on Medical Motion Pictures.

Chest Resuscitation Classes

The New London Community Hospital and the Wisconsin Heart Association recently gave instructions in closed chest resuscitation at a New London school. *Drs. Fred J. Pfeifer*, New London, *George P. Nichols*, Appleton, *D. J. Freeman*, Wausau, and Mr. Gerald R. Putzer conducted the instruction.

Talks on Artificial Implants

Dr. James D. Whiffen of University Hospitals, Madison, spoke on "Artificial Implants" at a public lecture held at Ripon College in cooperation with the Wisconsin Heart Association.

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NEWS OF WISCONSIN PHYSICIANS

Dr. Thatcher Elected to Pediatrics

Dr. L. Gilbert Thatcher, Madison, a member of the University of Wisconsin Medical School's Department of Pediatrics, was elected to fellowship in the American Academy of Pediatrics at the recent annual meeting of the group in Chicago.

Joins Madison Medical Center

Dr. Rudy A. Barta, Jr., pediatrician, has joined *Drs. A. M. Iams* and *C. R. Weatherhogg* in the Madison Medical Center, Madison. A graduate of the College of Wooster, Wooster, O., Doctor Barta received his medical degree at Western Reserve University. He interned at the University of Wisconsin's Children's Hospital, and returned for a year to the University's Department of Pediatrics after a two years' term in the Air Force.

Follows Father at Quisling Clinic

Dr. John D. Maloney, urologist, has joined the staff of the Quisling Clinic in Madison. He is the son of the late Dr. Frank Maloney who had been associated with the clinic for many years.

Doctor Maloney received his medical training at the University of Toronto. Previously he had attended Lawrence College and received a degree from the University of Wisconsin. He served two years internship and general surgery residence at Madison General hospital. While with the Air Force he was chief of surgery at Moody Air Force base in Georgia.

Dr. Sealby at Shawano Clinic

Newest member of the Cantwell–Peterson Clinic in Shawano is Dr. Robert L. Sealby, a graduate of the University of Michigan Medical School. After completing internship at the University of Iowa, he served for two years as medical officer at Homestead Air Force base in Florida before coming to Shawano.

Dr. Hendricks Joins East Madison Clinic

Dr. Richard J. Hendricks, internist, recently became a member of the staff at the East Madison Clinic, Madison. A graduate of the University of Notre Dame and Loyola University's Stritch School of Medicine, Chicago, Doctor Hendricks interned at St. Francis Hospital, Evanston, Ill., and was in residency at Veterans' Hospital, Hines, Ill. He recently completed two years with the Air Force.

Dr. Estrada to Head Florence County Clinic

Dr. Jesus I. Estrada, St. Louis, Mo., was recently engaged to head the new Florence County Medical Center. A general practitioner and surgeon, he will be assisted by his wife, Dr. de Leone Estrada, a heart and internal medicine specialist. Both are now practicing in a St. Louis hospital. Doctor Estrada hopes to move to Florence this spring and will be joined by his wife and children later in the summer.

Native Filipinos, both Doctors Estrada are now in the process of obtaining American citizenship. The two-physician medical center, now under construction, is being built by plans supplied by the Sears-Roebuck Foundation. Both doctors will work in affiliation with Dickinson County Memorial Hospital in Iron Mountain, Mich.

Dr. Jesus Estrada is a graduate of Santo Tomas University in Manila, P.I. As an exchange student he interned at Salt Lake City, Utah, and later worked at hospitals in Janesville and Milwaukee. He returned to Manila briefly, then he and his wife emigrated to the United States a year ago.

ABS Certifies Dr. Gant

Dr. Gerald C. Gant, Reedsburg, recently was certified by the American Board of Surgery. Doctor Gant, a 1958 graduate of the University of Wisconsin Medical School, completed his surgery training at University Hospitals, Madison, and later studied surgery of trauma at Kings County Hospital, Brooklyn, N. Y.

Dr. Tobin Lectures on LSD

The history and effects of LSD were discussed by *Dr. J. M. Tobin*, Eau Claire, at a supper meeting of the Bloomer Kiwanis Club recently. Doctor Tobin is a psychiatrist with the Northwest Psychiatric Clinic in Eau Claire.

Dr. Curreri Returns from Vietnam

Dr. Anthony Curreri, director of the division of clinical oncology at the University of Wisconsin Medical School, recently visited Vietnam as the mobilization designee in surgery for the Surgeon General. A full colonel in the United States Army and an authority on cancer, Doctor Curreri also attended the Ninth International Cancer Congress in Japan, where he spoke on "Clinical Drug Evaluation." He is chairman of the entire drug evaluation effort for the National Cancer Institute, which is screening drugs promising in the treatment of solid tumors. En route to Vietnam Doctor Curreri also stopped at Okinawa where he addressed the Torii Medical society.

Named to Water Pollution Board

Dr. James S. Vedder, Marshfield, was appointed in December to serve on one of the five regional

Physicians whose names appear in italics are members of the State Medical Society.

advisory boards set up by Governor Warren P. Knowles to aid Wisconsin's attack on water pollution. He will serve with others appointed from the Wisconsin Rapids district.

Joins Oconto Falls Hospital Staff

A new member of the Oconto Falls Community Memorial Hospital staff is *Dr. James Theisen*, surgeon, who formerly practiced for ten years in Green Bay. After graduating from the University of Wisconsin Medical School, Doctor Theisen served his internship and five years of surgical residency at St. Luke's Hospital, Cleveland, Ohio, and also practiced surgery at the Marshfield Clinic for a time. During his army service he was chief of surgery at Fort Stewart, Ga.

Dr. Hollero Joins Iola Hospital Staff

Dr. N. J. Hollero has taken over the practice of *Dr. C. F. Wood* in Iola. A native of the Philippines, Doctor Hollero came to Iola from Doctor's Hospital in Milwaukee. He served his internship at Santo Tomas Hospital in the Philippines and at St. Michael's in Milwaukee. Doctor Wood, who had served the Iola community since 1962, has joined a clinic in Wisconsin Rapids.

Dr. Theodore Rolfs Honored

—Photo courtesy FOX POINT BAYSIDE HERALD

Dr. Theodore Rolfs, left, accepts a testimonial resolution from *Dr. David Ovitt*, president of St. Mary's Hospital staff, at a recent clinic day at the Milwaukee hospital. Now retired, Doctor Rolfs was St. Mary's first intern in 1901. A graduate of the University of Illinois, he has been a practicing member of the hospital staff since 1906. Doctor Rolfs is a charter member of the American and Wisconsin Academies of General Practice.

Physician Serves on S.S. HOPE

Dr. Alfred M. Jerofke, Milwaukee, has recently completed a tour of service aboard the S. S. HOPE, famed white hospital ship which ended a ten-month medical teaching-treatment mission in Nicaragua. Doctor Jerofke, a volunteer, received his medical degree from the University of Heidelberg and is presently an assistant instructor in dermatology at Marquette University School of Medicine.

Joins Dean Clinic Staff

Dr. George P. Steinmetz, Jr., Madison, has joined the general surgery staff at the Dean Clinic. A graduate of the University of Wisconsin Medical School, he has been teaching for the past year there as an assistant professor of surgery. His specific field is general thoracic and cardiovascular surgery.

Directs Harvard Psychiatric Project

Dr. Leigh M. Roberts, assistant professor of psychiatry at the University of Wisconsin Medical School, is participating in an inter-university forum for educators in community psychiatry sponsored by Harvard University Medical School.

Doctor Roberts is collecting data on the experiences of the six American medical centers which are involved in the forum. Teachers of psychiatry from the six centers will meet twice a year in two-week sessions, conducting informal conferences with specialists in community psychiatry.

His particular work will be to analyze changes in the psychiatric residency training programs of the six institutions, and to compare these with similar programs of other institutions.

Reelected to Wausau Hospital Board

Dr. M. L. Jones, Wausau, was recently reelected president of the Wausau Memorial Hospital board. Other Wausau physicians, *Dr. Roy B. Larsen* and *Dr. A. H. Stahmer*, are serving on the hospital's executive committee. Doctor Jones and Doctor Stahmer were also reelected to the board of trustees.

Dr. Burandt Named to Pediatrics Academy

Dr. Donald C. Burandt, Beloit, was recently elected to fellowship in the American Academy of Pediatrics.

Receives Service Award

Dr. John L. Ford, Green Bay, recently headed a list of 21 St. Vincent Hospital employees and staff receiving service award pins. He was honored for 30 years' service as the hospital's pathologist.

Speak at Oshkosh Psychiatric Seminar

Two Oshkosh physicians, Dr. John McAndrew, psychiatrist at Winnebago State Hospital, and Dr. Thomas J. Kelly, clinical director at the hospital, spoke recently on current concepts of psychiatric illness and treatment before a state information seminar for clergy held in Oshkosh.

Edgerton Surgeon Discusses Vietnam Duty

Dr. Victor S. Falk, Edgerton surgeon who recently returned from two months of volunteer medical service in South Vietnam, described his experiences recently before Edgerton Senior Citizens.

Opens Pediatrics Office

A native of England, *Dr. Elizabeth Anne Terner* has opened a pediatrics office in Green Bay. Completing medical studies in England, she also interned at Milwaukee Children's Hospital. She is the wife of a Green Bay psychiatrist, Dr. Fred Terner.

Elected to Waupun Hospital Staff

Three physicians were recently elected officers of the Waupun Memorial Hospital Medical and Dental staff. They are *Drs. Rafael Barajas*, Waupun, *Theodore Rowan*, Beaver Dam, and *Stephen B. Hull*, Waupun.

Cites Changes in Public Health

Future sweeping changes in the public health field, and in particular in Wisconsin, were outlined by *Dr. George Handy*, acting assistant to the state health officer, at a recent meeting of the Wisconsin Rapids Rotary Club. A former Wisconsin Rapids physician, Doctor Handy left there two years ago to earn a master's degree in public health.

Dr. Harper Working in Vietnam

Dr. Samuel Harper, Madison, is completing two months in a South Vietnam field hospital. His voluntary assignment is under the supervision of the American Medical Association's plan, "Volunteer Physicians for Vietnam," which is attempting to keep 32 American physicians working in that country's provincial hospitals at all times. He is the sixth Wisconsin physician to serve under the AMA plan.

Dr. Netzow Elected to Fort Atkinson

The medical staff at Fort Atkinson Memorial hospital has named *Dr. E. J. Netzow*, Lake Mills, as chief of staff. Other officers elected are: *Dr. R. R. Liebenow*, Lake Mills, vice-chief of staff; *Dr. F. V. Beran*, Fort Atkinson, secretary-treasurer; *Dr. H. N. Hunsader*, Fort Atkinson, chief of medicine; *Dr. R. G. Handeyside*, Fort Atkinson, chief of obstetrics, and *Dr. R. W. Quandt*, Jefferson, chief of surgery.

Dr. Kronquist Certified in Pediatrics

Dr. Gordon E. Kronquist, Janesville, recently received his certification as a specialist in pediatrics from the American Board of Pediatrics. A graduate of the University of Wisconsin Medical School, he served his internship at St. Luke's Hospital, Cleveland, Ohio, and, after serving in the Naval Medical Corps, returned to St. Luke's to complete a two-year residency in pediatrics. Since 1964 he has been associated with the Pember–Nuzum Clinic in Janesville.

Sheboygan Falls Doctor Honored

Photo courtesy SHEBOYGAN PRESS

DR. H. J. HANSEN (right) of Sheboygan Falls is shown here with Don Meyer, Falls Jaycee president, and Senator William Proxmire, guest speaker, at the Future of Falls banquet during which Doctor Hansen received the Distinguished Service Award.

Dr. H. J. Hansen, a physician in Sheboygan Falls since 1933, recently was named recipient of the Distinguished Service Award by the Sheboygan Falls Junior Chamber of Commerce. Except for service as naval lieutenant commander in World War II, Doctor Hansen has spent 33 years of medical practice in Sheboygan Falls. He estimates that he has delivered over 3,000 babies in that time.

Four Attend VA Research Conference

Four Madison physicians from the Veterans Administration Hospital took part in the annual VA Medical Research conference recently held in Cincinnati, O.

Dr. Jerry S. Trier, chief of the gastroenterology section at VA hospital and an assistant professor at the University of Wisconsin Medical School, was co-chairman of a roundtable discussion of "Advances in Physiology of the Small Intestine."

Dr. J. M. B. Bloodworth, Jr., chief of the Laboratory Service at VA and a professor in the Medical School, took part in a discussion on "Experimental Models in Pathobiology and Ultrastructure."

Also attending the conference were Dr. George H. Burnett, associate chief of staff for research at VA, and *Dr. Gastone Celesia*, clinical investigator.

Talks on Childhood Diseases

Dr. J. S. Jeffrey, Kaukauna, spoke on "Childhood Communicable Diseases" at a recent meeting of the Park School Parent-Teacher association in Kaukauna.

Dr. Mally Practicing in Hartford

Dr. Michael J. Mally, internist, has joined *Dr. James L. Algiers* in his Hartford office. He attended the University of Detroit and earned his medical degree from Marquette University. After serving his internship at Marion County General Hospital in Indianapolis, Doctor Mally took up a residency in internal medicine at the Milwaukee County General Hospital before coming to Hartford.

Manilan Joins Marshfield Clinic

Dr. Cesar Reyes, Jr., a 1951 medical school graduate of the University of Santo Tomas in Manila, P.I., has joined the staff of the Marshfield Clinic.

Four Return from Brain Seminar in Chile

Four University of Wisconsin Medical School faculty members have returned from a seminar and workshop for visiting scientists sponsored by the International Brain Research organization, a UNESCO affiliate, held in Santiago, Chile.

Among those who attended was Dr. Clinton N. Woolsey, director of Wisconsin's Laboratory of Neurophysiology and the American organizer for the international seminar. He has been active in recent years in a Chilean–American exchange program for neurophysiologists, in which scientists from the University of Chile and the University of Wisconsin have taken part.

The three other Madison physicians who accompanied Doctor Woolsey were Dr. J. E. Rose and Dr. Vincente Montero, both of the Medical School's Laboratory of Neurophysiology, and Dr. Warner V. Slack, assistant professor of medicine and computer sciences.

Fox Lake Women Hear Dr. Pyle

Dr. Richard Pyle, clinical director at Waupun Central State Hospital, spoke recently on patient rehabilitation procedures at a meeting of the Fox Lake Woman's Club.

Dr. Quick Visits Home Town

A native of Theresa, *Dr. Armand Quick*, Milwaukee, a leader in the International Thrombosis Society and a former instructor at Marquette University, paid a visit to his former home town recently. It preceded a speaking tour which included an address by Doctor Quick at the Hemophilia Society in Chicago, then to Rodger, Ark., where he viewed his bloodclotting methods being put to use there, and finally to New Orleans, La., where he attended a meeting of the International Thrombosis Society.

Northwestern Wisconsin Physicians Meet

Northwestern Wisconsin area physicians who are alumni of the University of Wisconsin Medical School held a recent meeting at the Eau Claire Country club. Speakers were *Dr. Peter L. Eichman*, dean of the medical school, and *Dr. Thomas C. Meyer*, assistant dean. *Dr. Ben Lawton*, Marshfield, was master of ceremonies.

Dr. Joseph Heads La Crosse Board of Health

A La Crosse internal medicine specialist, *Dr. Leo G. Joseph*, has accepted the post of health officer for that city. He is also continuing his position as medical director at Hillview Home. Doctor Joseph has been associated with *Dr. F. W. Ernst* for nine years and recently took on a clinic practice with *Drs. Frank Gallagher* and *John J. Simones*. A native of Fond du Lac, Doctor Joseph served his residency in internal medicine at Veterans Administration Hospital in Iowa City, Ia., and at the University of Iowa Medical Center.

Dr. End Talks on Environment

Dr. Edgar End, assistant clinical professor of occupational and environmental medicine at the Marquette University School of Medicine, spoke on "Man's Reaction to Environment: In the Air and Below the Water" at a meeting of the American Interprofessional Institute of Milwaukee recently.

Physician Speaks on Child Problems

"Understanding Children's Problems" was the subject of a talk by *Dr. H. Kent Tenney* recently before members of the Sacred Heart Home School Association in Appleton. Doctor Tenney is an emeritus professor of pediatrics at the University of Wisconsin and director of the Wisconsin State Radio Network "March of Medicine" program.

Dr. Strong Completes Course in Boardmanship

Dr. Jack Strong, Mauston, has completed a three-year course in boardmanship and has been awarded a Certificate of Boardmanship by the Wisconsin Association of School Boards. Doctor Strong is a member of the Mauston Area School District Board of Education.

Dr. Bayley Talks on X-Ray Treatment

An insight into the complexities involved in x-raying parts of the human body was given by *Dr. Howard G. Bayley, Jr.*, Beaver Dam, recently to members of the Horicon Rotary Club. Doctor Bayley, who does all the x-ray work for St. Mary's Hospital, Columbus, Waupun Memorial Hospital, and St. Joseph's and Lutheran Hospital, Beaver Dam, showed slides on how bones and body shadows show up on x-ray film.

Eau Claire Physician Reports on Heart Ills

An explanation of the new intensive coronary care operation at Luther Hospital, Eau Claire, was given recently by *Dr. George Owen* to members of the Eau Claire Rotary Club. A new electrical machine to eliminate certain heart rhythm disturbances, now installed at Luther Hospital, is the first device of its kind in the state.

Monroe Opens New Medical Center

An estimated 2,000 visitors attended an open house at the Monroe Medical center recently. Greeting the visitors were the staff physicians, *Drs. C. E. Baumle, J. M. Irvin, D. W. Springer, C. O. Miller,* and *J. F. Murray.* Among the guests was *Dr. David D. Ruehlman,* Kenosha, a former Medical Center staff member. The newest member of the Center is Dr. Fernando Santiago, Chicago, a specialist in obstetrics and gynecology.

Dr. Westman Lauds La Crosse Guidance Clinic

Dr. Jack C. Westman, Madison, speaking recently in La Crosse on "Depressive Reactions in Children," praised the La Crosse County Guidance Clinic as a "pioneer in family diagnosis and treatment." Doctor Westman, a director of the University of Wisconsin Hospitals' child psychiatry division, said that a great deal of the credit goes to *Dr. Fredrik Midelfort* who helped start the clinic 20 years ago.

Dr. Cantwell Addresses Shawano Rotary

Dr. R. C. Cantwell of the Cantwell–Peterson Clinic in Shawano reviewed his 45 years of medical practice in the Shawano area in a talk recently before the Shawano Rotary club. He related some of the difficulties which faced him in his early years of practice and outlined recent medical advances which present hope in the future for both patient and physician.

Appointed Visiting Professor of Neurosurgery

Dr. A. Earl Walker, professor of neurosurgery at Johns Hopkins University School of Medicine, and chief of neurosurgery at Johns Hopkins Hospital, was appointed Helen Halverson Visiting Professor of Neurological Surgery recently at the University of Wisconsin Medical Center.

Dr. Fruchtman Appointed Associate Membership

Dr. Martin Z. Fruchtman, an internist specializing in allergic diseases, was recently granted an associate membership in the American College of Physicians. A fellow of the American College of Chest Physicians and a member of the American Society of Internal Medicine, Doctor Fruchtman practices in Waukesha.

New Associate in Delavan Practice

Dr. Benito B. Malit, a native of the Philippines, is a new associate with *Dr. Harold J. Werbel* in Delavan. He has just completed three years' residency at St. Elizabeth Hospital, Chicago. A graduate of Manila Central University, Doctor Malit interned at South Chicago Community Hospital. His wife, Dr. Miguela Malit, also holds a medical degree as an internist, but will not be practicing in Delavan at the present time.

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1. Bradley, J. E., *et al.*: J. Pediat. *38*:41 (Jan.) 1951.
2. Bradley, J. E.: Mod. Med. *20*:71 (Oct. 15) 1952.
3. Crunden, A. B., Jr., and Davis, W. A.: Am. J. Obst. & Gynec. *65*:311 (Feb.) 1953.

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PHYSICIAN NEWS *continued*

Radiologist Announces Green Bay Association

Dr. John Martin, Green Bay, has announced his association with *Drs. Lyle Edelblute* and *Loren Hart*. A native of Oshkosh, Doctor Martin is a graduate of Marquette University's School of Medicine. He received an Air Force scholarship which included two years of medical study followed by five years of active duty. He interned at Tripler General Hospital, Honolulu, Hawaii, while serving with the Air Force. After his discharge in 1963 he took his resident training at the Jackson Memorial Hospital, University of Miami, from 1963 until last June.

Coronary Care Unit Installed

New hope for heart attack victims is the unique intensive coronary care unit which has been established in Eau Claire's Luther Hospital. It is the first such operation in Wisconsin and one of the few which exist in hospitals throughout the United States, according to *Dr. John Wishart*, heart specialist at Luther and director of the unit.

Serves State Board of Health

Dr. William P. Curran, Antigo, was recently reappointed to a four-year committee term by the State Board of Health. He will continue as a member of the Advisory Committee on Hospital Rules and Standards.

Dr. Simons Retires at Whitehall

After 52 years of practice, most of it in the Whitehall area, *Dr. N. S. Simons* retired at the end of last year. A graduate of the University of Illinois Medical School, Chicago, he came to Whitehall in 1915. He was instrumental in the opening of the Community Hospital in 1917, now Tri-County Memorial Hospital, and was on its staff since the beginning. Following an enlistment in the medical corps in World War I, Doctor Simons began specializing in eye, ear, nose, and throat. Subsequently he took postgraduate work at Columbia University and had a year of residency at New York Ophthalmic Hospital. He also studied in Vienna, Austria.

From 1919 until 1956 he was associated with the late Dr. R. L. MacCornack at the MacCornack Clinic in Whitehall. Since 1960 he has practiced on a part-time basis. Two years ago he became a member of the State Medical Society's Fifty Year Club.

Aids in Racine Selection

Dr. Louis T. Maxey, Milwaukee, was one of four judges recently named to select Racine's "outstanding man of the year."

Dr. Gabriel Opens Wausaukee Office

After a year without a resident physician, the village of Wausaukee has welcomed Dr. Reynaldo P. Gabriel, a native of the Philippines. A medical graduate of the University of Santo Tomas in

"COCA-COLA" AND "COKE" ARE REGISTERED TRADE-MARKS WHICH IDENTIFY ONLY THE PRODUCT OF THE COCA-COLA COMPANY.

Manila, Doctor Gabriel was engaged as resident in four Chicago area hospitals before going to West Allis where he served for three years as surgical resident at West Allis Memorial Hospital.

Dr. Rudy Joins Dean Clinic

Dr. Ronald C. Rudy, Minneapolis, Minn. has joined the Dean Clinic, Madison, as a practitioner of orthopedic surgery. A graduate of the Marquette University School of Medicine, he served his internship at Charles T. Miller Hospital, St. Paul, Minn. After two years of medical service at Great Lakes Naval Training Station, Doctor Rudy was a resident at the Veterans Administration Hospital, Minneapolis.

Dr. Heinz Heads Sheboygan Staff

Dr. Harold N. Heinz was recently elected president of the St. Nicholas Hospital Medical staff in Sheboygan. He succeeds *Dr. P. A. Sciarra* in the one-year post. Other new officers are *Dr. Robert Senty*, vice-president, and *Dr. Otto Stewart*, secretary.

Becomes U. S. Citizen

A native of Germany, *Dr. Eric Schmidt*, Berlin, Wis., recently became a United States citizen. He opened practice for one year in Redgranite before moving to Berlin in 1962. He was appointed Berlin city health officer in 1965 and last year was named a state medical consultant at Winnebago Hospital.

Dr. Loomis Is 102 in Janesville

Janesville's oldest resident, Dr. Edward A. Loomis, observed his 102nd birthday on December 1. Confined to the Colonial Manor Nursing home with arthritis, he conversed with his wife, 95, who resides in the family residence. Doctor Loomis, who says he eats an apple a day, contributes his longevity to the fact that "I have taken darned good care of myself."

Heads Superior Hospital staff

Dr. C. W. Giesen has been elected chief of staff of the St. Mary's Hospital medical and dental staffs in Superior. Also elected to posts were *Dr. R. T. Anderson*, president-elect, and *Dr. Enzo Krahl*, secretary-treasurer.

New Obstetrician at Madison Clinic

A specialist in obstetrics and gynecology, *Dr. W. James Siverhus*, Madison, is a new associate at the Dean Clinic. A graduate of the University of Minnesota Medical School, he interned at St. Mary's Hospital, Duluth, and took his residency in obstetrics and gynecology at the University of Wisconsin Hospitals.

Pediatrician Joins Menasha Group

The Riverside Clinic has announced the addition of Dr. G. Douglas Reilly, pediatrician, to its medical staff. A Michigan native, Doctor Reilly received his medical degree from the University of Michigan Medical School. He interned at Oakwood Hospital, Dearborn, Mich., before going into military service. For the past two years he has been a resident in pediatrics at the University of Minnesota, receiving additional training in infections and blood diseases of children.

Dr. Stiehl Leaves Algoma Practice

Dr. C. W. Stiehl, Algoma physician and surgeon, who became well known in Door County for his utilization of cherry juice in making wine, has left Algoma for a new career in industrial medicine in Milwaukee.

Doctor Stiehl has taken over the practice of *Dr. Julius Heil*, which involves the medical directorship of the Heil Company in Milwaukee. He is also serving on the panel of Cutler-Hammer and plans, in addition, to open a private surgical practice. However, he will continue on the staff of Algoma Memorial Hospital and will return to Algoma at intervals to perform surgery there.

Specialist Now in California

Dr. Rudolf Pyka, an orthopedic specialist at the Marshfield Clinic for six years, has now entered private practice at Redlands, Calif.

Dr. Price Talks on Bladder Cancer

"Studies Regarding the Causes of Bladder Cancer" was the subject of a recent talk by Dr. James M. Price of the University of Wisconsin Medical School. He spoke in La Crosse at a press conference in observance of the 20th anniversary of the Wisconsin Division of the American Cancer Society. Doctor Price is a lifetime research professor of the Society. A report on educational projects in the state was made at the conference by *Dr. Gerald I. Uhrich*, La Crosse, president of the Wisconsin Division.

New Addition to Waupun Clinic

An internist, Dr. Ernesto Camacho, a native of the Philippines, has joined the Waupun Clinic. A graduate of Manila Central University, he prac-

Tape on Marriage Popular

"Marriage on the Rocks" was found to be the most often requested medical information tape in the University of Wisconsin Medical School's new telephone-access library of tapes. In operation only six months, the library reports its second most popular request has been for a treatment of bee stings. So far the library has received 946 requests for information from Wisconsin and 33 other states. The 88 telephone tapes are available 24 hours a day to physicians.

ticed medicine there for three years before coming to the United States. After three years training in internal medicine at St. Agnes Hospital, Baltimore, Md., he completed another year of specialization in pulmonary diseases at Glendale Hospital, Glendale, Md. Later he was assistant director of the State Tuberculosis Hospital, Madisonville, Ky.

Dr. Albrecht Wins Magazine Award

Dr. James E. Albrecht, Jackson, has been awarded a certificate for one of the "best articles by a physician" submitted to MEDICAL ECONOMICS magazine. He was among several physicians throughout the country honored by the magazine.

Mount Sinai Appoints Dr. Ansfield

The board of directors at Mount Sinai Hospital, Milwaukee, has appointed *Dr. David J. Ansfield* as chief of its medical staff. An orthopedic surgeon, he is a graduate of the University of Wisconsin Medical School. Department heads appointed by the hospital board are *Dr. Barney B. Becker*, surgery; *Dr. Foster J. Jacobson*, obstetrics and gynecology; *Dr. Kiesl K. Kaufman*, medicine, and *Dr. Burton M. Zimmermann*, general practice.

Milwaukeeans Present Papers

Dr. W. H. Frackelton, Milwaukee surgeon, spoke on "The Planning of Reconstructive Surgery of the Hand," at the recent Third Annual Symposium on Surgery of the Hand held in Philadelphia.

At the Urological Pre-Congress Meeting of the International College of Surgeons in Merida, Yucatan, Mexico, Milwaukee urologist *Dr. R. E. Pollard* spoke on "Urethroplasty in Female Urethrotrigonitis."

MU Awarded Runyon Grant

A $8,200 grant for the project "Characterization of the Normal Malignant Trophoblast in Tissue Culture" has been awarded for the second year in a row to a Marquette University's School of Medicine obstetrics–gynecology project, directed by *Dr. Richard F. Mattingly*. The grant is extended by the Damon Runyon Memorial Fund.

Author of Article on Shooting

A Madison anesthesiologist, *Dr. John McAleavy*, describes indoor rifle practice methods as author of an article in a recent issue of THE AMERICAN RIFLEMAN. He is also coach of the 14th Corps rifle team at Camp McCoy.

Dr. Sattler Now at Marshfield

Dr. James R. Sattler, radiologist, is now associated with the Marshfield Clinic. He leaves private practice in Indianapolis, Ind. to take the Marshfield post. A graduate of Marquette University's School of Medicine, Doctor Sattler interned at Sacred Heart Hospital in Allentown, Pa., followed by three years in radiology residency at Hurley Hospital in Flint, Mich. He completed Air Force duty as a captain in Tripoli, Libya, and North Africa.

Heads Hospital Campaign Division

Dr. William S. Middleton, emeritus dean of the University of Wisconsin Medical School, has been named chairman of the gifts division of the Greater Madison Hospitals Expansion campaign. His group has the responsibility of soliciting pledges of hospital employes, members of the board of directors, the medical staff, the women's auxiliary, and the nurses alumnae. A graduate of the Medical School, Doctor Middleton served as its dean from 1935 to 1955. He was also chief medical director of the Veterans Administration from 1955 to 1963.

Doctors Move Into New Center

Four physicians are now occupying a new medical center, The Professional Plaza, in Burlington. The physicians are *Drs. H. W. Granzeau, D. J. Baker, E. Paul Gander*, and *Robert Wheaton*.

Dr. Sholl Heads Mercy Staff

Dr. P. Richard Sholl, surgeon, has been elected president of the Mercy Hospital medical staff, Janesville. He succeeds *Dr. John Tordoff*. A graduate of Dartmouth, Doctor Sholl received his medical degree from Harvard University in 1946. He began practicing in Janesville in 1954 after internship and residency at Hitchcock Clinic, Hanover, N. H., and a fellowship at the Mayo Foundation, Rochester, Minn.

Other new members of the executive staff at Mercy are: *Dr. Everett Reinardy*, chief of staff; *Dr. Donald Knepel*, secretary-treasurer; *Dr. Thomas Sargeant*, medicine; *Dr. Gerald Gredler*, surgeon; *Dr. Jack Schroeder*, general practice; *Dr. Gordon Kronquist*, pediatrics; *Dr. J. S. Pennepacker*, pathology; *Dr. Marvin Roesler*, radiology; and *Dr. James O'Brien*, obstetrics–gynecology.

Dr. Quisling in Chamber of Commerce

Dr. Abraham Quisling, Madison, a partner in the Quisling Clinic, has been elected to a post on the Madison Chamber of Commerce. He will serve this year as vice-president of the civil-industrial division of the Chamber.

Attends Cardiology Symposium

Dr. Richard H. Wasserburger, professor of medicine at the University of Wisconsin Medical School, and chief of cardiology at Veterans Hospital, Madison, was a member of the faculty at a symposium recently in Minneapolis. The two day series of conferences on "Practical Office and Bedside Cardiology" was presented by the American Therapeutic Society's education program, in conjunction with the Minnesota Heart Association.

Psychiatrist Opens Glendale Office

Dr. Richard Vodegel has opened an office to practive psychiatry in Glendale. He received a medical degree from the University of Amsterdam, the Netherlands, and also graduated in psychiatry from the University of Wisconsin. Doctor Vodegel is also the medical director of the Ozaukee County Mental Health clinic in Port Washington.

Dr. Pavlic Explores ESP Interests

Dr. Robert Pavlic, Brookfield obstetrician and gynecologist, discussed "ESP—Mind or Matter" at a recent meeting of the New Berlin Women's Club. Doctor Pavlic is widely known for his interest in mental telepathy and has appeared before many audiences and on the Jack Paar show. He has offices in Brookfield and West Allis and is also a clinical instructor at Marquette University School of Medicine.

Dr. Middleton Talks on the Heart

The Madison Woman's Club recently heard a talk on "Diet and Heart Disease" by *Dr. William S. Middleton*, emeritus dean of the University of Wisconsin Medical School. Former chief medical director for the Veterans Administration, he now serves as a consultant at the Madison VA hospital.

Describes RH Work at St. Joseph's

New techniques which have improved the RH blood type conflict in newborn infants was described by *Dr. Edward J. Buerger* at the 10th annual clinic day held recently at St. Joseph's Hospital, Milwaukee. Doctor Buerger, chief resident in obstetrics and gynecology, outlined the new method—originated at St. Joseph's—in which fluid is withdrawn from the uterus and analyzed to determine peril of the fetus. This technique is now being applied at several other Milwaukee hospitals, he added.

Uses of Silicone Boon to Surgery

The use of silicone in various forms has proved a valuable aid to plastic surgery, reported *Dr. Jack L. Teasley* recently in a talk at St. Mary's Hospital clinic day in Milwaukee. He especially noted the use of liquid silicone and its favorable results in breast surgery. *Dr. David W. Ovitt*, surgeon and chief of staff at St. Mary's, added that the prosthesis might prove particularly valuable for women suffering from fibrocystic breast disease.

Dr. Evrard Talks at Hales Corners

"The Fundamental Beauty of Womanhood" based on the physical changes in the development of a woman, was the subject of a recent talk by *Dr. John R. Evrard*, Milwaukee obstetrician and gynecologist, at a meeting of the Hales Corners Woman's Club. His talk was a part of the Medical Society community health information service, which is operated as a public service by The Medical Society of Milwaukee County.

Dr. Anderson 25 Years at River Pines

As River Pines sanatorium, Whiting, celebrates its 60th anniversary this year, its medical director, *Dr. Henry A. Anderson* will also observe his 25th year with the institution. River Pines is the oldest tuberculosis hospital in the state. One of the first x-ray machines equipped to take chest films was installed at the hospital about 1916.

—Photo courtesy STEVENS POINT DAILY JOURNAL

Dr. Henry A. Anderson, left, was guest of hanar recently at a surprise dinner party at River Pines Sanatorium, Whiting, in observance of his 25th anniversary as medical directar of thot institution. Here Doctor Anderson and his wife are being congratulated by clase friends, Mr. and Mrs. H. A. Graver.

Two Physicians Serve in Vietnam

Two Wisconsin physicians currently serving in the 85th Evacuation Hospital in Qui Nhon, Vietnam, are Dr. Michael C. Kubly, Monroe, and *Dr. Arthur C. Plautz, Jr.*, Milwaukee. Doctor Kubly, an orthopedic surgeon, and Doctor Plautz, an urologist, serve in the two-acre complex of quonset huts and tents which comprise this second largest military hospital in Vietnam. Doctor Kubly is a 1958 graduate of the University of Wisconsin and received his medical degree in 1963 from Marquette University School of Medicine.

Serves on Family Life Panel

Dr. William Funcke, Beaver Dam physician, served with four other Dodge County professional men on a family life panel discussion in Beaver Dam. During the discussion, which combined a joint meeting of the Beaver Dam Mayor's Commission on the Status of Women and the American Association of University Women, Doctor Funcke pointed out that many family problems stem from a physical illness which can also become an emotional one. He added that many doctors give counseling on a very superficial basis.

Dr. Cunningham at Quisling Clinic

Dr. Milfred A. Cunningham has joined the orthopedic surgery department of Quisling Clinic, Madison. Doctor Cunningham received his M.D. degree from the University of Wisconsin Medical School and interned at Madison General Hospital. While in medical school, he was employed by the State Medical Society.

Dr. Dailey Observes Practices

Photo courtesy MONROE EVENING TIMES

Dr. Arthur D. Dailey (right), who is in his second year of specialty training in dermatology at the University of Wisconsin, Madison, spends one day a week observing at St. Clare Hospital, Monroe, and in the dermatology department of The Monroe Clinic. His supervisors are Drs. Robert R. Baumann (left) and *Thomas L. Watt* (center), both dermatologists at The Monroe Clinic and part time clinical instructors in dermatology at the UW Medical School.

African Hospital Dedicated to Doctor

A new hospital at Chicuque, Africa, has been dedicated in memory of the late Dr. Charles John Stauffacher. A native of Sylvester Township, Green County, Doctor Stauffacher spent 44 years in Africa as a medical missionary.

New Milwaukee Blood Center Director

Dr. S. P. Masouredis has been appointed Executive Director of the Milwaukee Blood Center, according to a recent announcement by Robert B. Trainer, president of the board of directors. Doctor Masouredis will succeed *Dr. Tibor J. Greenwalt*, who left the position at the close of 1966 to direct the National Red Cross Blood Program in Washington, D. C.

The new Executive Director, who will take over his duties at the close of the present school year, at present is associate professor of medicine at the University of California Medical School, San Francisco, a post he has held since 1962. He is also research associate of the Cancer Research Institute, staff specialist in hematology, clinical laboratories, and chief of the blood bank of the medical school.

A graduate of Cass Technical High School in Detroit, Doctor Masouredis obtained his A.B. from the University of Michigan in 1944 and his M.D. from the medical school of that university in 1948. He obtained a Ph.D. in medical physics from the University of California at Berkeley in 1952, where he became a member of the faculty in 1950 as a clinical instructor in medicine.

During 1955–1959 he was on the faculty of the University of Pittsburgh where he served, too, as assistant director of the Central Blood Bank of that city. He returned to the University of California Medical School in 1959 as associate professor of preventive medicine. He spent the year prior to September 1966 in Switzerland under fellowships provided by the National Heart Institute and the Eleanor Roosevelt International Cancer Fellowship of the International Union Against Cancer, doing research at the University of Lausanne.

Dr. Cooper Named to Health Board

Dr. G. A. Cooper, clinical professor of medicine at the University of Wisconsin, Madison, was appointed February 6 to the State Board of Health by Gov. Warren Knowles. Doctor Cooper succeeds Jacob E. Kaufman of DePere.

Doctor Cooper has served two terms on the Madison Community Welfare Council and is a director of the Dane County–Madison Community Health Planning Council.

Dr. Stebbins Honored for Madison Community Work

A WISCONSIN STATE JOURNAL weekly column, "Know Your Madisonian," which highlights community leaders, recently featured a Madison physician, *Dr. George G. Stebbins.*

A member of the Madison medical community since 1931, Doctor Stebbins was on the original committee to form the Dane County Blood Bank. He has been a member of the Madison YMCA for 30 years and once served as president of its board of directors. Twice director of the Madison Community Chest, Doctor Stebbins, a geriatrist, has been involved for 16 years in that group's committee on aging. He has also worked for 16 years on the Welfare Council and served the Wisconsin State Board of Health as an advisor to nursing homes.

Doctor Stebbins has been affiliated with the downtown Rotary Club since 1951, serving in various years as director and vice-president. He was also president of the Madison Service Clubs' Council for a year.

Doctor Stebbins was born in Mt. Vernon where his father, Dr. Walter Stebbins, now 92, practiced for a time. He earned a degree in pharmacology from the University of Wisconsin and received his medical degree from Harvard School of Medicine in 1928. After interning in New York City, he taught for six years at the University of Wisconsin Medical School before joining his father's medical practice in Madison.

MEETINGS AND SPECIAL EVENTS HELD AT THE STATE MEDICAL SOCIETY "HOME" DURING THE MONTH OF JANUARY 1967

3 Postgraduate Medical Education Committee, Wisconsin Regional Medical Program
3 Board of Trustees, Dane County Medical Society
3 Madison Urological Society
3 Madison Anesthesiology Society
3 Surgical Staff, Madison General Hospital
5 Division on Handicapped Children
5 Program Committee, Wisconsin Health Council
5 *State Board of Health (Madison)*
10 Geriatrics Advisory Committee, Dane County Medical Society
12 UW "In Depth" Scientific Program
13 Nelson Muffler Corporation
14 Committee on Occupational Health
14 Osteopathy Conference
14 Executive Committee of the Council
18 Dinner for Dr. Charles L. Hudson, President of the American Medical Association
18 Coding Committee, State Clinic Managers Association
19 Commission on Hospital Relations and Medical Education
25 Committee on Grievances
26 Advisory Committee on Hospital Utilization Review Committee
28 Executive Committee, CES Foundation
29 Division on Nervous and Mental Diseases
30 Woman's Auxiliary, Dane County Medical Society

Meetings not held in the Society "Home" but have a direct relationship are printed in italics, with the location in parentheses.

JANUARY—AT SOCIETY HEADQUARTERS

AMA President Hudson Visits Wisconsin

In a three-day whirlwind tour of Wisconsin, the president of the American Medical Association, Dr. Charles L. Hudson, voiced his opinion of Medicare and its ramifications and then outlined the broad programs being conducted by the AMA in such areas as disease prevention, research, medical education, and the many problems confronting the practice of medicine today.

On January 16, Doctor Hudson spoke to the Sheboygan Rotary Club who had invited members of the Sheboygan County Medical Society. January 17 he appeared before the Milwaukee Academy of Medicine who also had invited area physicians. And on January 18, Doctor Hudson addressed students, faculty, and interested public at Wayland Academy's Memorial Chapel in Beaver Dam.

In concluding his visit in Wisconsin, Doctor Hudson was the honored guest at a dinner at the State Medical Society headquarters in Madison. A representative group of Wisconsin physicians, including those closely connected with AMA activities and a few Madison area physicians, were among those attending.

Doctor Hudson came to Wisconsin directly from a medical conference in Washington, D.C. where news media had inaccurately headlined his press conference remarks by quoting him as saying "MDs Don't Object to Medicare Now."

THE HONORED GUEST at a small dinner party at State Medical Society headquarters, Dr. Charles L. Hudson, president of the American Medical Association, is flanked on the left by *Dr. E. J. Nordby*, vice-chairman of the Council, Madison, and W. J. Brown, field representative of the AMA, Chicago; on the right by *Dr. Frank E. Drew*, president of the Society, Milwaukee; C. H. Crownhart, secretary of the Society, Madison; and *Dr. E. M. Desslach*, chairman of the Commission on Medical Care Plans, Prairie du Chien.

The national coverage of this headline ruffled the normally gentle-mannered Doctor Hudson who used his Wisconsin visits to quite frankly set the record straight as to the physician's viewpoint of Medicare and the objectives to which doctors must strive.

Doctor Hudson expressed these major points:

. . . Physicians have been performing their services quietly and conscientiously under Medicare and the public may feel that they have no objections to Medicare. This is not the case.

. . . The AMA will continue to oppose Medicare in principle.

. . . Physicians must become active in the planning of health services for the poor.

. . . Physicians have a moral obligation to back up with action what they maintain—that they will see to it that everyone has access to good health care.

. . . Physicians must deny criticism that they "have it so good" practicing among more favored individuals that they can overlook those less fortunate.

Dr. W. J. Urben Honored for Service

Dr. Walter J. Urben, superintendent of the Mendota State Hospital since 1948, was guest of honor December 21 at a reception for more than 100 physicians and their wives at State Medical Society headquarters in Madison. Doctor Urben's colleagues on the Division on Nervous and Mental Diseases of the Commission on State Departments arranged for the affair to honor him upon his resignation from the Division and "for his devoted service to public health and welfare."

Doctor Urben has been an active leader in the state's mental health program and has worked closely with the State Medical Society through its Division.

From 1942 to 1947 he was director of the state Division of Mental Hygiene of the Department of Public Welfare. In 1948 he was appointed superintendent at Mendota State Hospital which at the time was having many problems. Service and treatment were handicapped because of a lack of money and public interest. Doctor Urben, with the help of his staff and the legislature, has completely transformed the hospital into a successful and highly desirable facility for the benefit of its patients and in the interest of the public. Under Doctor Urben's leadership the hospital's building complex and treatment program have been significantly expanded.

During his years with the public welfare department and Mendota State Hospital, Doctor Urben has served the State Medical Society either as a liaison representative of the welfare department or as a committee member of the variously named Society committees involving mental health, now known as the Division on Nervous and Mental Diseases.

AN ENGRAVED TRAY beoring the 125th Anniversory medollion of the State Medicol Society wos presented to Dr. *Wolter J. Urben* (center) by Dr. *Gilbert J. Tybring*, o member of the Division on Nervous ond Mental Diseoses. Mrs. Urben is shown ot the left.

SOME OF THE GUESTS ot the reception honoring Dr. *Wolter J. Urben* ore shown obove, left to right: Dr. ond Mrs. *Le Roy A. Ecklund*, clinicol director of Mendota Stote Hospital ond Doctor Urben's successor on the Division on Nervous ond Mentol Diseases of the Commission on Stote Deportments; Dr. ond Mrs. *Leonord J. Ganser*, director of the Division of Mentol Hygiene of the Stote Deportment of Public Welfore ond o lioison representative for the deportment to the Society's Division; Mr. ond Mrs. Wilbur J. Schmidt, director of the Stote Deportment of Public Welfore; ond Dr. ond Mrs. *T. W. Tormey, Jr.*, secretory of the Stote Boord of Medical Exominers ond chairmon of the Society's Commission on Stote Deportments.

Controversies in Medicine

THEME FOR 1967 ANNUAL MEETING

STATE MEDICAL SOCIETY OF WISCONSIN

MAY 9–11
MILWAUKEE

JOHN K. CURTIS, M.D.
General Chairman

The Commission on Scientific Medicine is pleased to invite you to the 1967 Annual Meeting of the State Medical Society of Wisconsin, in Milwaukee, May 9 through 11, to take part in the many discussions which will be conducted around the general theme: Controversies in Medicine. Many subjects offer opportunities to review varying opinions on diagnosis and treatment that the Commission has asked all component groups to plan programs in keeping with the general theme of the meeting.

We feel the 1967 Annual Meeting will be stimulating for all members and we hope you will plan your schedule so you can be in attendance. On the following pages we are listing a brief digest of the scientific program. Full details of the entire meeting will be carried in the March issue of the WISCONSIN MEDICAL JOURNAL.

Sincerely,

JOHN K. CURTIS, M. D.
Chairman, Commission on Scientific Medicine

Controversies in Medicine

TUESDAY, MAY 9

MORNING GENERAL SCIENTIFIC PROGRAMS

1. MEDICAL TREATMENT OF SHOCK
   F. S. Simeone, MD, Cleveland
   Wesley Spink, MD, Minneapolis

2. TREATMENT OF THYROID DISEASE
   O. H. Beahrs, MD, Rochester, Minn.
   Robert C. Meade, MD, Milwaukee
   Thomas F. Nikolai, MD, Marshfield

LUNCHEONS

1. SURGICAL MANAGEMENT OF INFLAMMATORY DISEASE OF THE INTESTINAL TRACT
   O. H. Beahrs, MD, Rochester, Minn.

2. TELOGNOSIS: CLOSED-SYSTEM TELECOMMUNICATIONS
   J. Gershon-Cohen, MD, Philadelphia

3. OBESITY AND DIABETES
   E. S. Gordon, MD, Madison

4. VIRAL ETIOLOGY OF LEUKEMIA AND LYMPHOMAS
   Ludwik Gross, MD, Bronx, N. Y.

5. CURRENT METHODS OF INDUCING OVULATION
   Richard Mattingly, MD, Milwaukee

6. IATROGENIC DISEASE
   W. S. Middleton, MD, Madison

7. PRE- AND POSTOPERATIVE CARE OF THE SURGICAL PATIENT
   F. S. Simeone, MD, Cleveland

8. CURRENT PROBLEMS IN ANTIBACTERIAL THERAPY
   Wesley Spink, MD, Minneapolis

9. PREVENTION OF RHEUMATIC HEART DISEASE—MODERN METHODS
   Jeremiah Stamler, MD, Chicago

AFTERNOON SCIENTIFIC PROGRAMS

1. INTERNAL MEDICINE
   (with Wisconsin Society of Internal Medicine)
   (a) DIET AND OTHER FACTORS IN THE TREATMENT OF ATHEROSCLEROSIS
   Jeremiah Stamler, MD, Chicago
   (b) TREATMENT OF ATHEROSCLEROSIS
   Jeremiah Stamler, MD, Chicago
   Edgar S. Gordon, MD, Madison
   Norman Engbring, MD, Milwaukee
   William Parsons, MD, Madison

2. GENERAL SURGERY
   (a) SMALL BOWEL OBSTRUCTION
   F. S. Simeone, MD, Cleveland
   (b) LOW ANTERIOR RESECTION FOR TREATMENT OF CANCER OF THE COLON AND RECTUM
   O. H. Beahrs, MD, Rochester, Minn.
   DISCUSSANTS
   Adolph Gundersen, MD, La Crosse
   Richard Lillie, MD, Milwaukee

3. PATHOLOGY
   (with the Wisconsin Society of Pathologists)
   (a) ONCOGENIC VIRUSES
   Ludwik Gross, MD, Bronx, N. Y.
   (b) THE BOVINE PAPILLOMA VIRUS
   Carl Olson, DVS, Madison
   (c) VARIETIES OF MOLECULAR DEFECTS IN CHEMICAL CARCINOGENESIS
   Van R. Potter, PhD, Madison

4. RADIOLOGY (Mammography and Radiotherapy)
   (with Wisconsin Radiological Society)
   (a) MAMMOGRAPHY
   J. Gershon-Cohen, MD, Philadelphia
   (b) RADIOTHERAPY vs RADIOCHEMOTHERAPY
   Robert J. Samp, MD, Madison
   Frank F. Gollin, MD, Milwaukee
   Joyce Kline Pulletti, MD, Madison
   John Mokrohisky, MD, Green Bay
   Maurice Greenberg, MD, Milwaukee

WEDNESDAY, MAY 10

MORNING GENERAL SCIENTIFIC PROGRAMS

1. HORMONE THERAPY IN WOMEN . . . FOREVER?
   Saul Gusberg, MD, New York City
   Ben M. Peckham, MD, Madison

2. PRESENT STATUS OF RADIOISOTOPES IN DIAGNOSIS
   John R. Cameron, PhD, Madison

SPECIAL MORNING PROGRAM ON RESIDENT AND INTERN PAPERS

Competition and cash awards. Details in March Journal.

LUNCHEONS

1. HAZARDS IN RADIATION
   John R. Cameron, PhD, Madison

2. SELECTION OF TREATMENT FOR UTERINE CANCER
   Saul Gusberg, MD, New York City

3. WHITHER INFECTIONS?
   Mark H. Lepper, MD, Chicago

4. NEWER DRUGS AND THEIR USES
   Ovid O. Meyer, MD, Madison

5. SUBJECT PENDING
   Oglesby Paul, MD, Chicago

6. CAUSE AND PREVENTION OF MYOCARDIAL INFARCTION
   William H. Sewell, MD, Sayre, Pa.

7. MANAGEMENT OF ACUTE INSUFFICIENCY DUE TO CHRONIC OBSTRUCTIVE LUNG DISEASE
   Gordon L. Snider, MD, Milwaukee

8. INDUCTION OF OVULATION WITH CLOMIPHENE AND PERGONAL
   William Spellacy, MD, Minneapolis

9. EVALUATION AND MANAGEMENT OF SUICIDAL PATIENTS
   Carl Wold, PhD, Los Angeles

AFTERNOON SCIENTIFIC PROGRAMS

1. CARDIOVASCULAR DISEASES
   (with Wisconsin Heart Association)
   (a) MEDICAL AND SURGICAL MANAGEMENT OF CORONARY ARTERY DISEASE
   William Sewell, MD, Sayre, Pa.
   Oglesby Paul, MD, Chicago
   (b) GRADED EXERCISES IN MANAGEMENT OF CORONARY ARTERY DISEASE
   Oglesby Paul, MD, Chicago
   Bruno Balke, MD, Madison

2. OBSTETRICS AND GYNECOLOGY
   (with Wisconsin Society of Obstetrics and Gynecology)
   (a) DIABETES MELLITUS AND PREGNANCY: Management and Current Research
   William N. Spellacy, MD, Minneapolis
   (b) ENDOCRINE CASE STUDIES
   Saul Gusberg, MD, New York City
   William Spellacy, MD, Minneapolis
   Ben M. Peckham, MD, Madison
   Richard Mattingly, MD, Milwaukee
   Eleanor Delfs, MD, Milwaukee

3. PEDIATRICS
   (with Wisconsin Chapter of American Academy of Pediatrics)
   (a) WHEN SHOULD ANTIBIOTICS BE WITHHELD?
   Mark H. Lepper, MD, Chicago
   Burton Waisbren, MD, Milwaukee
   (b) PREMATURE DEATHS ("Probably Preventable")
   Richard Stiehm, MD, Madison
   Stanley Graven, MD, Madison

4. PSYCHIATRY
   (with Wisconsin Psychiatric Association)
   (a) SOCIAL AND MEDICAL RESPONSIBILITIES IN SUICIDE
   Carl Wold, PhD, Los Angeles
   Gordon Johnsen, Madison
   John Kluwin, Milwaukee
   Charles Landis, MD, Milwaukee
   A. A. Lorenz, MD, Eau Claire

THURSDAY, MAY 11

MORNING GENERAL SCIENTIFIC PROGRAMS

1. KIDNEY DISEASE: Transplants vs Dialysis
   Satoru Nakamoto, MD, Cleveland
   Robert Burns, MD, Madison

2. CARE OF THE DYING
   George E. Collentine, Jr., MD, Milwaukee
   Rev. Dr. Paul B. McCleave, Chicago
   Paul S. Rhoads, MD, Chicago
   Rabbi Manfred Swarsensky, Madison

MORNING SPECIAL SPECIALTY PROGRAMS

1. OPHTHALMOLOGY
   Program followed by lunch and afternoon meeting. Details in March Journal.

2. OTOLARYNGOLOGY
   (a) THE UBIQUITOUS TONSILLECTOMY
   Maxine Bennett, MD, Madison
   Charles Lobeck, MD, Madison
   P. J. Noonan, MD, Milwaukee
   F. J. Vlazny, MD, Milwaukee

   (b) SURGERY FOR BELL'S PALSY?
   Irving M. Blatt, MD, New Orleans
   Sanford Larson, MD, Milwaukee
   Henry Peters, MD, Madison
   Henry Williams, MD, Minneapolis

3. SURGERY
   The Wisconsin Surgical Society will conduct a morning teaching program at one of the Milwaukee hospitals, and all MDs are invited to attend. Details in the March Journal.

LUNCHEONS

1. NEW TRENDS IN MANAGEMENT OF CARDIAC ARRHYTHMIAS DURING ANESTHESIA
   Joseph Buckley, MD, Minneapolis

2. ANESTHETIC ALARMISTS
   James E. Eckenhoff, MD, Chicago

3. JOINT INJURIES
   Ruth Jackson, MD, Dallas, Tex.

4. OPHTHALMOLOGY
   The Section of Ophthalmology will hold a special luncheon and business meeting, followed by a scientific program with *Dr. Lorenz Zimmerman*, Washington, D. C., as guest speaker.

5. HOME DIALYSIS WITH A MAKE-IT-YOURSELF ARTIFICIAL KIDNEY
   Satoru Nakamoto, MD, Cleveland

6. ANTIBIOTICS IN DERMATOLOGY
   Harold O. Perry, MD, Rochester, Minn.

7. MODERN CONCEPTS OF PYELONEPHRITIS
   Paul S. Rhoads, MD, Chicago

8. CHRONIC RHINOSINUSITIS AND ITS RELATION TO DISEASE OF THE LOWER RESPIRATORY TRACT
   Henry Williams, MD, Minneapolis

AFTERNOON SCIENTIFIC PROGRAMS

1. ANESTHESIA
   (with Wisconsin Society of Anesthesiologists)
   (a) WHY USE ANY AGENT OTHER THAN NITROUS OXIDE AND HALOTHANE?
   Joseph J. Buckley, MD, Minneapolis
   James E. Eckenhoff, MD, Chicago
   David J. Noll, MD, Madison

   (b) SHOULD VASOPRESSORS BE DISCARDED?
   James E. Eckenhoff, MD, Chicago
   Joseph J. Buckley, MD, Minneapolis
   Sherwood W. Gorens, MD, Milwaukee

2. DERMATOLOGY
   (with Wisconsin Dermatological Society)
   (a) PROBLEM CASES
   Cases provided by Milwaukee dermatologists.
   DISCUSSANT: *Harold O. Perry, MD*, Rochester, Minn.

   (b) PEMPHIGUS, PEMPHIGOID OR DERMATITIS HERPETIFORMES?
   Harold O. Perry, MD, Rochester, Minn.

3. OPHTHALMOLOGY
   (with Section on Ophthalmology)
   Details in March Journal.

4. ORTHOPEDIC SURGERY
   (with Wisconsin Society of Orthopedic Surgery)
   (a) CERVICAL STRAIN
   Ruth Jackson, MD, Dallas, Tex.

   (b) PANEL ON CERVICAL STRAIN
   Moderator: *Herman W. Wirka, MD*, Madison
   Charles J. Frankel, MD, Charlottesville, Va.
   Ruth Jackson, MD, Dallas
   Mr. John Linster, Wausau

5. SURGERY
   (with Wisconsin Surgical Society)
   Details in March Journal.

OUT-OF-STATE GUEST SPEAKERS

O. H. BEAHRS, MD, Rochester, Minn.
Professor of Surgery, Mayo Graduate School of Medicine

IRVING M. BLATT, MD, New Orleans, La.
Professor and Head, Department of Otorhinolaryngology, Louisiana State University School of Medicine

JOSEPH BUCKLEY, MD, Minneapolis, Minn.
Professor of Anesthesiology, University of Minnesota Medical School

BEAHRS

BLATT

BUCKLEY

JAMES E. ECKENHOFF, MD, Chicago, Ill.
Professor and Chairman of Anesthesia, Northwestern University Medical School

CHARLES J. FRANKEL, MD, Charlottesville, Va.
Associate Professor of Orthopedic Surgery and Instructor in Medical Law, University of Virginia

J. GERSHON-COHEN, MD, DSc (Med), Philadelphia, Pa.
Professor of Radiologic Research, Temple University School of Medicine

LUDWIK GROSS, MD, Bronx, N. Y.
Chief, Cancer Research Unit, Veterans Administration Hospital

ECKENHOFF

GERSHON-COHEN

GROSS

SAUL GUSBERG, MD, New York, N. Y.
Professor and Chairman of Obstetrics and Gynecology, Mt. Sinai School of Medicine

RUTH JACKSON, MD, Dallas, Tex.
Assistant Clinical Professor of Orthopedic Surgery, University of Texas Southwestern Medical School

GUSBERG

JACKSON

LEPPER

MARK H. LEPPER, MD, Chicago, Ill.
Professor of Preventive Medicine, University of Illinois at The Medical Center; and Executive Vice President, Professional and Academic Affairs, Presbyterian St. Luke's Hospital

REV. DR. PAUL B. McCLEAVE, Chicago, Ill.
Director, Department of Medicine and Religion, American Medical Association, Chicago

SATORU NAKAMOTO, MD, Cleveland, O.
Staff Member, Department of Artificial Organs, Cleveland Clinic

McCLEAVE

NAKAMOTO

PERRY

OGLESBY PAUL, MD, Chicago, Ill.
Professor of Medicine, Northwestern University School of Medicine

HAROLD O. PERRY, MD, Rochester, Minn.
Consultant in Dermatology, Mayo Clinic; Associate Professor of Dermatology, Mayo Graduate School of Medicine, University of Minnesota

PAUL S. RHOADS, MD, Chicago, Ill.
Professor of Medicine (Emeritus), Northwestern University Medical School

WILLIAM SEWELL, MD, Sayre, Pa.
Chief of Cardiac Surgery, Guthrie Clinic

RHOADS

SEWELL

SIMEONE

SPELLACY

SPINK

STAMLER

F. S. SIMEONE, MD, Cleveland, O.
Professor of Surgery, Western Reserve University School of Medicine, and Cleveland Metropolitan General Hospital

WILLIAM N. SPELLACY, MD, Minneapolis, Minn.
Assistant Professor of Obstetrics and Gynecology, University of Minnesota Medical School

WESLEY SPINK, MD, Minneapolis, Minn.
Professor of Medicine, University of Minnesota Medical School

JEREMIAH STAMLER, MD, Chicago, Ill.
Director, Heart Disease Control Program, Chicago Board of Health; Executive Director, Chicago Health Council; Research Associate Professor of Medicine, Northwestern University Medical School

HENRY WILLIAMS, MD, Minneapolis, Minn.
Chief of Otorhinology & Laryngology, VA Hospital

CARL WOLD, PhD, Los Angeles, Calif.
Chief Psychologist, Suicide Prevention Center

LORENZ ZIMMERMAN, MD, Washington, D. C.
Chief, Ophthalmic Pathology Branch, Armed Forces Institute of Pathology

WOLD

ZIMMERMAN

LET THESE GUIDES HELP YOU

The following guides and manuals have been prepared at the direction of a number of councils, commissions, divisions, and committees of the State Medical Society to be of direct personal assistance to the physician or his county society. Each is available without cost upon request to the State Medical Society office, Box 1109, Madison, Wisconsin 53701.

Interprofessional Code
An instrument for better understanding between attorneys and physicians with reference to medical testimony and interprofessional conduct and practices.

Guide to The Service Corporation Law
A series of questions and answers describing Chapter 350, Laws of Wisconsin, 1961, allowing physicians, among others, to form private medical corporations for the tax benefit of their stockholders.

Code of Necropsy Procedure
A guide to physicians, hospitals, and funeral directors in the performance of necropsies.

Hearing Conservation Programs for Wisconsin Industries
Some recommended standards and principles for providing a hearing conservation program in industry.

Occupational Health, A Guide for Medical and Nursing Personnel
General principles and suggested plans for an industrial health program, with emphasis on written procedure for nurses.
New expanded edition—$5.00 with binding, $4.00 without binding. Ideal for any industrial plant with nurse service.

Find Your Future in the Health Field
A career guide (the health careers brochure).

Guide to Immunization Planning
An approved guide including recommended procedures for routine immunizations, parental responsibility, physician responsibility, medical society responsibility and steps for successful community planning.

Inspection of Medical Records
An interpretation of Chapter 301, Laws of 1959 relating to the right of access to physician and hospital records concerning patient care. Sample consent forms are included.

Principles for Transporting the Ill and Injured
A guide for providing emergency transportation services, including model community and state ordinances.

School Vision Screening Program
An outline to facilitate the development of a program to detect significant visual defects among school children.

First Aid Chart

Guide to Interpretation of Chapter 484, Laws of Wisconsin, 1959
Relating to fee splitting between physicians and others.

ANNUAL PHOTOGRAPHY CONTEST

MILWAUKEE AUDITORIUM, MILWAUKEE * MAY 9–11, 1967
OPEN TO MEMBERS OF THE STATE MEDICAL SOCIETY

CLASSIFICATIONS

Medicine, Travel, People (at play and at work), Animals, Pictorial (landscape—things—still life, etc.).

ENTRIES

There is no limit to the number of entries allowed to any exhibitor. All entries must be at the State Medical Society headquarters in Madison on or by April 1, 1967.

REQUIREMENTS

(1) All entries must be mounted on white mounting boards 16 x 20 inches only. Boards will be exhibited in vertical position only; (2) Prints may be of any size up to 16 x 20 inches if verticals, 11 x 14 if horizontals; (3) Prints must be placed singly on mounting boards; (4) Entries must carry the following information on the back of the mounting: Title, class entered, name and address of exhibitor. There shall be no writing or printing on the front of the mounting board or on any photo; (5) All photos entered must be taken by the entrant but developing, enlarging and mounting need not be done by him.

AWARDS

Each division, black and white or color, will be judged separately and the following awards given to each classification: First place, second place and third place. In addition, three honorable mention awards will be given to each classification. There will be an award of "Best In Show" given to the best entry, either black and white or color. Trophies will be given to all first place winners and to the "Best In Show" and ribbons for all other awards.

JUDGING

Judging will take place prior to the showing of entries at the Annual Meeting. Winners will be notified of their awards as soon after judging as possible.

MAIL TODAY

PHOTO CONTEST ENTRY

Mail to State Medical Society of Wisconsin, P. O. Box 1109, Madison, Wis. 53701
BEFORE YOU SUBMIT YOUR ENTRY.

All entries must be submitted before April 1, 1967.

Name _____

Address _____

	BLACK & WHITE	COLOR	TOTAL
Medicine	_____	_____	_____
Travel	_____	_____	_____
People	_____	_____	_____
Animals	_____	_____	_____
Pictorial	_____	_____	_____

A Special Annual Meeting Feature

MEDICAL ART SALON

SPONSOR: The Woman's Auxiliary to the State Medical Society of Wisconsin

CO-CHAIRMEN: Dr. and Mrs. Reuben Snartemo, and Dr. and Mrs. Harry Watson, Jr., Milwaukee

MILWAUKEE AUDITORIUM . . . MAY 9–11, 1967

Sculptures and Paintings (watercolors and oils only)

WHO MAY EXHIBIT: Any member of the State Medical Society of Wisconsin or his **wife.**

LIMITED ENTRIES: Up to 3 entries per person.

DEADLINE FOR ENTRIES: All notifications of "Intent to Exhibit" must be in the hands of Dr. and Mrs Reuben Snartemo, Milwaukee, on or before April 1, 1967. (Early notification will be appreciated, so that proper facilities for the entire exhibit can be planned in advance. Mail your entry blank below as soon as possible.)

REQUIREMENTS: (1) All pictures must be framed with wire and screw eyes attached. (2) Works of sculpture must not exceed 24 inches in height. (3) All entries must be delivered to the Dressing Room on the east side of the stage of Bruce Hall, Milwauwkee Auditorium between 8:00 a.m. and 10:00 a.m., Monday, May 8, and must be picked up in the display area between 3:30 p.m. and 5:00 p.m., Thursday, May 11.

JUDGING AND AWARDS: Ribbons for first, second, and third places in each of the three categories (sculpture, watercolor painting, oil painting) will be awarded, plus a "popularity award" based on votes of all those who view the Art Salon.

LIMITED LIABILITY: The submitter must assume full responsibility for work submitted, but every care against damage or theft will be exercised. Guard will be provided during the course of the display.

NOTIFICATION OF INTENT TO EXHIBIT

Mail to Dr. and Mrs. Reuben Snartemo, 5529 W. Jackson Park Drive, Milwaukee, Wis. 53219, BEFORE APRIL 1, 1967.

I plan to submit the following entry or entries for the 1967 MEDICAL ART SALON at the Milwaukee Auditorium, May 9–11.

My entry, or entries, will be:

(1) Painting ____ Title _____ ☐ watercolor ☐ oil size _____" wide and _____" deep

(2) Painting ____ Title _____ ☐ watercolor ☐ oil size _____" wide and _____" deep

(3) Painting ____ Title _____ ☐ watercolor ☐ oil size _____" wide and _____" deep

(1) Sculpture __ Title _____ size _____" wide and _____" high

(2) Sculpture __ Title _____ size _____" wide and _____" high

(3) Sculpture __ Title _____ size _____" wide and _____" high

Name: _____ Street: _____

City: _____

OBITUARIES

Dr. James E. Forsyth, 54, who had been a psychiatrist on the Winnebago State Hospital staff, died May 10, 1966, in Oshkosh.

Born in Battle Creek, Mich., Doctor Forsyth received his M.D. degree from Northwestern University Medical School, Chicago, and interned at Hurley Hospital, Flint, Mich. He practiced general medicine in Albion, Mich., for 17 years before taking postgraduate work in psychiatry at Tulane University, New Orleans, and Warren State Hospital, Warren, Pa. He had been on hospital staffs in North Dakota and Louisiana before locating in Oshkosh.

Doctor Forsyth was a past member of the Winnebago County Medical Society, State Medical Society of Wisconsin, and American Medical Association.

Survivors are his widow, Winifred, and two children, Priscilla and Michael.

Dr. John P. Fetherston, Sr., 70, former chief physician for the Milwaukee Fire Department and long time general practitioner, died Oct. 18, 1966, in Milwaukee. For many years he was also an examining physician for the State Athletic Commission.

After his graduation from Marquette University School of Medicine, Milwaukee, in 1924 and his internship at Milwaukee County Hospital, Doctor Fetherston established his Milwaukee practice, which he maintained until his retirement in 1962. He served on the staffs of St. Joseph's, St. Anthony, and St. Michael hospitals and the Muirdale Sanatorium. The son of a fireman, Doctor Fetherston was a fire department physician from 1950 to 1964, and he estimated that he had been called to 200 fires.

Doctor Fetherston was a member of The Medical Society of Milwaukee County, State Medical Society of Wisconsin, American Medical Association, American Academy of General Practice, Catholic Physician's Guild, and a past president of the American College of Chest Physicians.

Survivors include his widow, Anne; two daughters, Mrs. Stuart Desmond, Fox Point, and Mrs. Frederick Lahmann, Potomac Hills, Md.; and four sons, Dr. John P., Jr., and Robert F., both of Fox Point, Dr. Thomas J., of Glendale, and Raymond P. of Whitefish Bay.

Dr. Martin K. Rosenbaum, 63, who had an EENT practice in Cudahy where he had also been chief-of-staff at Trinity Memorial Hospital for two years, died Oct. 21, 1966, in Milwaukee.

Doctor Rosenbaum attended the University of Wisconsin Medical School, Madison, and was graduated from Yale University Medical School, New Haven, Conn., in 1928. He interned at Mount Sinai Hospital, Milwaukee, where he was later an attending physician. He received his EENT training at the University of Vienna.

Doctor Rosenbaum was a member of The Medical Society of Milwaukee County, State Medical Society of Wisconsin, and American Medical Association.

Surviving are his widow, Pearl; a daughter, Jane A.; and a son, James L.

Dr. Frank A. Gruesen, 68, who practiced general medicine in Fort Atkinson for more than 30 years until his retirement in 1964, died Nov. 7, 1966, at his home in Peoria, Ill. While in Fort Atkinson, he had been chief-of-staff at Memorial Hospital.

Born in Duluth, Minn., Doctor Gruesen was graduated in 1929 from Marquette University School of Medicine, Milwaukee, and he interned at Madison General Hospital.

He was a member of the Jefferson County Medical Society, State Medical Society of Wisconsin, American Medical Association, and Wisconsin Academy of General Practice.

Surviving are his widow, Geneva; two sons, Dr. Robert, Green Bay, and Frank A., Jr., Peoria; and a daughter, Mrs. John Hanson, Peoria.

Dr. S. W. Simonson, 60, internist who had practiced in Dallas, Wis., at the MacCornack Clinic in Whitehall, and at the Gundersen Clinic in La Crosse, died Nov. 4, 1966. Doctor Simonson had retired in 1962 and lived in Prairie Lake. He is survived by his widow, Viola.

Dr. John J. McCarthy, 63, retired physician who practiced in Sun Prairie until 1934, died Nov. 7, 1966, in Green Bay. He was a 1928 graduate of Marquette University School of Medicine, Milwaukee. Surviving is his mother, Mrs. John McCarthy, Marion Home, Oshkosh.

Dr. Edward F. Daley, 46, Manawa general practitioner, died Nov. 30, 1966, in Green Bay. He had practiced in Green Bay for eight years and in Gillett for two years before moving to Manawa in 1960. Survivors are his widow, Shirley; a son, Ted, at home; a daughter, Cathy, a student at Stevens Point; and a brother, Dr. George, Milwaukee.

* * *

MEDICAL RESEARCH with lasers at Veterans Administration hospitals has presented evidence that use of the laser may be good technique for treating some types of liver tumors since almost bloodless removal of parts of the liver are possible with this method.

* * *

ASK YOUR social security district office for Form OAR-7004 and check the accuracy of your account at least every three years.

SOCIETY RECORDS

MEMBERSHIP REPORT AS OF NOVEMBER 28, 1966

NEW MEMBERS

John H. Beaumier, 630 S. Central Ave., Marshfield 54449.
Orhan G. Bingol, 132 Beloit St., Walworth 53184.
Alf F. Borge, 134 N. Leonard St., West Salem 54669.
William M. Brennan, N82 W15401 Appleton Ave., Menomonee Falls 53051.
Adam Brish, 6225 Seventh Ave., Kenosha 53140.
James R. Brown, 622 E. Lowe's Creek Rd., Eau Claire 54701.
Haakon P. Carlson, 590 Fourth St., Prairie du Sac 53578.
Nazario R. Cruz, 2108—63rd St., Kenosha 53140.
Robert J. DeWitt, 516 Houston St., Marinette 54143.
Jose Diaz-Esquivel, 630 S. Central Ave., Marshfield 54449.
David E. Goodnough, 1836 South Ave., La Crosse 54601.
William B. Grubb, Jr., 332 W. Seymour St., Appleton 54911.
Robert D. Heinen, 1113 Main St., Oconto 54153.
D. B. Johnson, 146 S. Eau Claire St., Mondovi 54755.
L. M. Lawton, Wittenberg Clinic, Wittenberg 54499.
Michael J. Mally, 332 Jefferson Ave., Hartford 53027.
Robert J. Meyer, Box 35, Spring Valley 54767.
Ruben A. Nepomuceno, P. O. Box 255, Black Creek 54106.
John F. Sullivan, 1906 N. Elinor St., Appleton 54911.
Som D. Varma, 17155 W. Mary Ross Dr., New Berlin 53151.
Robert J. Ware, Hazel Green Clinic, Hazel Green 53811.
Jeffrey L. Warren, 103 W. College Ave., Appleton 54911.
John C. Zeiss, 1620 N. Meade St., Appleton 54911.

CHANGES OF ADDRESS

G. L. Backer, 630 First St., Wausau 54401.
W. D. Backer, 630 First St., Wausau 54401.
R. I. Bender, 205 S. University Ave., Beaver Dam 53916.
L. L. Bensman, Mt. Sinai Hosp., 948 N. 12th St., Milwaukee 53233.
John L. Burns, Jr., 630 S. Central Ave., Marshfield 54449.
Elizabeth Comstock, Arcadia, to Neillsville Nursing Home, Neillsville 54456.
John E. Connolly, 3rd Surgical Hosp. (MBL), APO San Francisco 96491, Calif.
L. G. Crocker, 20 S. Park St., Madison 53715.
Alan A. Ehrhardt, Winneconne, to 5743 D Hazel-Wood Cir., #6, Baltimore, Md. 21206.
Peter J. Groessl, 122 W. Mission Rd., Green Bay 54301.
Donald C. Hampel, Milwaukee, to 453 Buena Vista Ave., East, San Francisco, Calif. 94117.
R. G. Handeyside, Palmyra, to 210 Madison Ave., Fort Atkinson 53538.
John Hartwick, New Berlin, to 2956 N. 50th, Milwaukee 53210.
S. H. Holt, Route 1, Box 446-B, Kenosha 53140.
John T. McManus, Cola, S. C., to 2026 N. Snelling, Roseville, Minn. 55113.
Delbert P. Nachazel, Jr., Milwaukee, to 102 E. Main St., Waukesha 53186.
Herman D. Nienhuis, 221 W. Court St., Janesville 53545.
Charles J. Pophal, Milwaukee, to Long Beach Naval Hosp., Long Beach, Calif.
Jose R. Relacion, Elm Grove, to 4675 N. 106th St., Milwaukee 53225.
James F. Reynolds, Green Bay, to 6728 W. Trail, Minneapolis, Minn. 55400.
A. J. Richtsmeier, 20 S. Park St., Madison 53715.
J. J. Robb, 319 S. Monroe, Green Bay 54301.
Mac C. Roller, West Lafayette, Ind., to 1551 N. Main St., Franklin, Ind. 46131.
Thomas R. Sawyer, 811 E. Wisconsin Ave., Milwaukee 53202.
Etheldred L. Schafer, 30 S. Henry St., Madison 53703.
John L. Sella, Waterville, Me., to 6114 W. Capitol Dr., Milwaukee 53216.
James B. Shack, 3343 Douglas Ave., Racine 53402.
William Sickels, Menasha, to 24719 Fries Ave., Wilmington, Calif.
Neil Swissman, Milwaukee, to 12028 N. Lake Shore Dr., Mequon 53092.
Joseph Syty, Viroqua, to Route 1, Sun Prairie 53590.
Lester H. Verch, Milwaukee, to 10425 W. North Ave., Wauwatosa 53226.
Thomas W. Weis, Wauwatosa, to 9537 W. Brookside Dr., Greenfield 53228.
Richard L. Wesenberg, Los Angeles, Calif., to 8741 Littlewood Rd., Baltimore, Md. 21234.
W. R. Yutuc, 13525—15th Pl., N.E., Seattle, Wash. 98125.

REMOVED FROM MEMBERSHIP

Elmer E. Bertolaet, Milwaukee County, resigned.
Harold E. Booker, Dane County.
George E. Burgermeister, Dodge County, transferred to Oregon.
James C. Chung, Racine County, removed per County Secretary.
Karl F. Finnen, Winnebago County, removed per County Secretary.
John H. Fodden, Manitowoc County.
Harry Y. Fredrick, Columbia–Marquette–Adams County.
Robert J. Gardner, Eau Claire–Dunn–Pepin County, transferred to West Virginia.
Edgar A. Hawk, Dane County, transferred to Indiana.
P. S. Johnson, Racine County.
Paul E. Kaschel, Langlade County, transferred to Michigan.
Joseph C. Kiser, Dane County.
Ronald E. Lemmons, Manitowoc County, transferred to Texas.
Donald M. Nowinski, Marathon County.
Russell H. Owen, Dane County.
Thomas E. Stevens, Winnebago County, transferred to Kentucky.
Thomas F. Way, Dane County.

DEATHS

James E. Forsyth, Winnebago County, May, 1966.
John P. Fetherston, Sr., Milwaukee County, October 18, 1966.
M. K. Rosenbaum, Milwaukee County, October 21, 1966.
S. W. Simonson, non-member, November 4, 1966.
Frank A. Gruesen, Jefferson, November 7, 1966.
John J. McCarthy, non-member, November 7, 1966.
Robert O. Brunkhorst, Milwaukee County, November 19, 1966.

NEW MEMBERS

Adali, Ilhan S., 2001 S. Tenth Ave., South Milwaukee 53172.
Bandelin, Valerie R., 6308 Eighth Ave., Kenosha 53140.
Barrett, David A., II, 926 Milwaukee Ave., South Milwaukee 53172.
Brown, John F., 819 E. Summit Ave., Oconomowoc 53066.
Burg, Richard M., 1321 Tompkins Dr., Madison 53716.
Carek, Donald J., 1700 W. Wisconsin Ave., Milwaukee 53233.
Cornell, John W., 4602 S. Packard Ave., Cudahy 53110.
Dega, Francis J., 123 N. Military Ave., Green Bay 54303.
Goetz, Roger A., V. A. Center, Wood 53193.
Helm, Frederic C., 6626 W. Vienna, Milwaukee 53216.
Hollero, N. J., 4702 N. 18th St., Milwaukee 53209.
Kullerstrand, Donald S., 900 S. Webster, Green Bay 54301.
Lehman, Roger H., V. A. Center, Wood 53193.
Nocella, Reynold A., 1220 Dewey Ave., Wauwatosa 53213.
Olson, Neiland R., 3039 S. 82nd St., Milwaukee 53219.
Pelland, Philip C., 3316 W. Wisconsin Ave., Milwaukee 53208.
Pizer, Evan F., 1601 Cameron Dr., Madison 53711.
Schlueter, Donald P., 8700 W. Wisconsin Ave., Milwaukee 53226.
Scott, John C., 7930 W. O'Connor St., Milwaukee 53214.
Shindell, Sidney, 561 N. 15th St., Milwaukee 53233.
Stewart, William C., 8919 W. Hampton Ave., Milwaukee 53225.
Terner, Elizabeth Anne, 180 St. Mary's Blvd., Green Bay 54301.

CHANGES OF ADDRESS

Appleby, Keith B., Wauwatosa, to 2800 W. Wright St., Milwaukee 53210.
Backus, Edward A., 3527 N. 61st St., Milwaukee 53216.
Brish, Adam, Kenosha, to 1414 W. Fair Ave., Marquette, Mich. 49855.
Cohill, Donald F., Shawano, to 307 Tyson Ave., Glenside, Penn. 19038.
Colgan, H. J., 1215 Doctors Dr., Neenah 54956.
Cutshall, Roger A., Burnsville, Minn., to V. A. Hospital Quarters 18A, Sheridan, Wy. 82801.
Dall, Glenn A., Elm Grove, to 10625 W. North Ave., Wauwatosa 53226.
Damiano, N. F., P. O. Box 100, Hales Corners 53130.
Englander, Stanley M., 3760 N. Bay Dr., Racine 53402.
Fueredi, Adam, 1390 Cedar Creek Pkwy., Grafton 53024.
Grubb, William B., Jr., 34 River Dr., Appleton 54911.
Hellmuth, George A., Milwaukee, to Box 163, Route 1, Hartford 53027.
Holl, John W., San Francisco, Calif., to 718 Bond St., North Manchester, Ind.
Hollero, Numeriano J., Milwaukee, to Iola 54945.
Kloppedal, Erling A., Prairie du Sac, to U. S. Army Hosp., Fort Gordon, Ga. 31751.
Landmann, G. A., Jr., 105 W. Milwaukee, Tomah 54660.
Marx, Arnold J., 1212 Gilbert Rd., Madison 53711.
Nemcek, Albert A., Milwaukee, to 2970 Santa Maria Dr., Brookfield 53005.
Orman, Edward S., 1110 Frisch Rd., Madison 53711.
Raymond, Lou A., 605 Walker Ave., Eau Claire 54701.
Riesch, John D., N85 W17679 Ann Ave., Menomonee Falls 53051.
Ryan, Paul, 231 W. Michigan St., Milwaukee 53203.
Schulz, Irwin, 811 E. Wisconsin Ave., Milwaukee 53202.
Snyder, John Frazier, III, 3776 N. 53rd St., Milwaukee 53216.
Speckhard, Mark, West Bend, to 126 Maryland, Dyess AFB, Tex. 79607.
Thatcher, Donald S., 811 E. Wisconsin Ave., Milwaukee 53202.
Theisen, James, Green Bay, to 248 N. Main St., Oconto Falls 54154.
Trettin, Robert J., 811 E. Wisconsin Ave., Milwaukee 53202.
Verch, Lester H., 10625 W. North Ave., Wauwatosa 53226.
Voytek, Joseph J., 220 W. First Ave., Latrobe, Penn. 15650.
Warren, Jeffrey L., 103 W. College Ave., Appleton 54911.
Werner, David J., 425 E. Wisconsin Ave., Milwaukee 53202.
Wolfe, C. W., 10625 W. North Ave., Milwaukee 53226.
Wood, Charles F., Iola, to 441 Mead Cir., Wisconsin Rapids 54494.

REMOVED FROM MEMBERSHIP

Bachman, Charles H., Milwaukee County.
Becker, Robert M., Dane County, removed per county secretary.
Brose, Merle L., Waukesha County.
Brown, William M., Jr., Milwaukee County.
Frable, Mary A., Milwaukee County, resigned.
Frable, William J., Milwaukee County, resigned.
Handte, Robert E., Milwaukee County, removed per county secretary.
Johnson, Joseph Richard, Dane County, resigned.
Kring, Gerald G., Dane County, resigned.
Leagus, Charles J., Jr., Milwaukee County, transferred to New Jersey.
Lee, James M., Milwaukee County.
Levinson, Bernard, Milwaukee County.
McDuffie, James J., Milwaukee County.
Onkst, Harold R., Milwaukee County, transferred to Florida.
Pawlowski, Joseph M., Milwaukee County, transferred to California.
Rawland, John G., Milwaukee County.
Standard, Anna L., Milwaukee County.
Wolters, Herbert F., Milwaukee County.

CORRECTION

It was inadvertently reported in the December issue, at page 62, in the Society Records section that Dr. Robert W. Schroeder had changed his address from Fond du Lac to Beloit. Doctor Schroeder is still practicing at 92 East Division Street in Fond du Lac. There was some confusion in the fact that there are two Doctor Robert W. Schroeders practicing in Wisconsin.

DEATHS

Seymer, Lewis A., Milwaukee County, Nov. 17, 1966.
Gatterdam, Paul C., La Crosse County, Nov. 29, 1966.
Daley, Edward F., non-member, Nov. 30, 1966.
Dempsey, George P., Milwaukee County, Dec. 6, 1966.
Juster, Eugene M., Dane County, Dec. 15, 1966.
Overman, Meric V., Clark County, Dec. 17, 1966.
Pippin, B. I., non-member, Dec. 24, 1966.

WISCONSIN LICENTIATES

The following physicians were granted licenses by oral and written examination by the State Board of Medical Examiners at a meeting in Milwaukee, July 13, 14, 15, 1965.

Name	*School of Graduation*	*Year*	*City*
Boone, Judith Ann	University of Wisconsin	1964	N. Y., N. Y.
Cavanaugh, John H.	University of Iowa	1965	Nashville, Tenn.
Flader, William A.	University of Wisconsin	1964	Madison
Hayes, Matthew J.	University of Freiburg, Germany	1964	Schofield
Lawton, Ledra M.	University of Freiburg, Germany	1964	Wittenberg
Leite, Joaquim D.	Medical School of Oporto	1960	Wood
Plotkin, Allen S.	University of Wisconsin	1965	Galveston, Tex.
Powondra, Philip F.	University of Wisconsin	1965	Milwaukee
Prieto, Jose C.	University of Havana	1944	Milwaukee
Reynosa, Gustavo	University of Nuevo Leon	1958	Milwaukee
Rosenberg, Robert H.	University of Wisconsin	1965	Milwaukee
Wichman, Harvey M.	University of Wisconsin	1965	Louisville, Ky.

The following physicians were granted licenses by oral examination by the State Board of Medical Examiners at a meeting in Milwaukee, July 14, 1965.

Name	*School of Graduation*	*Year*	*City*
Adair, Stuart E.	Marquette University	1964	Forbes AFB, Kan.
Chiu, John T.	University of Vermont	1964	Milwaukee
Harding, Harold W.	University of Illinois	1964	Wauwatosa
Michels, Terry A.	University of Wisconsin	1964	Middleton
O'Brien, William A.	University of Minnesota	1946	Minneapolis, Minn.
Quanbeck, David T.	University of Chicago	1962	Madison
Tauras, Arvydas P.	University of Illinois	1964	Milwaukee
Wanetick, Lawrence H.	Chicago Medical School	1963	Milwaukee
Whitaker, Carl A.	Syracuse University	1936	Madison

The following physicians were granted licenses by oral examination by the State Board of Medical Examiners at a meeting in Madison, October 8, 1965.

Name	*School of Graduation*	*Year*	*City*
Carroll, Marion L., Jr.	Meharry Medical College	1964	Milwaukee
Chason, Jacob L.	University of Michigan	1940	Royal Oak, Mich.
Lundgren, Ralph J.	University of Cincinnati	1962	Ft. Knox, Ky.
Mitchell, Robert H.	Indiana University	1943	Park Ridge, Ill.
Moritz, Walter D.	Northwestern University	1964	Chicago, Ill.
Murley, Gordon D.	University of Illinois	1962	Milwaukee
Paulsen, William	University of Wisconsin	1964	Madison
Roth, Harry	Western Reserve University	1962	Madison
Ryan, Allan J.	Columbia University	1940	Madison
Slesh, Marvin Z.	Ohio State University	1962	Middleton
Sorensen, Raymond E.	University of Illinois	1936	Des Plaines, Ill.
Wall, Simeon H.	University of Tennessee	1964	Madison
Waun, James E.	Wayne State University	1960	Madison
Williams, Irving C.	Howard University	1964	Milwaukee

The following physician was granted a license by oral examination by the State Board of Medical Examiners at a meeting in Madison, Jan. 12, 1966.

Name	*School of Graduation*	*Year*	*City*
Rice, David B.	University of Virginia	1964	Madison

The following physicians were granted licenses by oral examination by the State Board of Medical Examiners at a meeting in Madison, April 22, 1966.

Name	*School of Graduation*	*Year*	*City*
Andrew, Reed C.	University of Michigan	1958	Green Bay
Bandelin, Valerie R.	University of Illinois	1963	Des Plaines, Ill.
Bellehumeur, Gerald C.	Marquette University	1963	Milwaukee
Chun, Wallace H.	Indiana University	1956	Milwaukee
Dega, Francis J.	Loyola University	1960	Green Bay
Fisher, Terrance N.	Marquette University	1962	Beltsville, Md.
Friend, Charles R.	University of Michigan	1956	Marshfield
Gowan, Lawrence R., Jr.	Marquette University	1955	Duluth, Minn.
Greenlee, Herbert	University of Chicago	1955	Madison
Haidinyak, Anton L.	University of Toronto	1954	La Crosse
Hansen, Steven V.	Western Reserve University	1960	Wauwatosa
Hauss, Quincy R.	University of Michigan	1961	Redding, Calif.
Hoggatt, John E.	Northwestern University	1961	Racine
Lempke, Lloyd W.	Indiana University	1961	W. Lafayette, Ind.

Name	*School of Graduation*	*Year*	*City*
McCutcheon, Malcolm M.	University of Wisconsin	1961	Neenah
McIntyre, Robert E.	New York Medical College	1960	Madison
McKee, Donald C.	University of Nebraska	1958	La Crosse
Mejia, Gualberto B.	University of Santo Tomas	1956	Clinton
Murray, Rosemary	University of Arkansas	1957	Wauwatosa
Nocella, Reynold A.	Georgetown University	1956	Milwaukee
Parker, Edward C.	Marquette University	1964	Milwaukee
Parker, Marvin G.	University of Missouri	1960	Racine
Parnell, Diana D.	Georgetown University	1965	Madison
Parnell, Francis W.	Georgetown University	1965	Madison
Randazzo, Salvatore	University of Palermo	1923	Wauwatosa
Raneses, Jovencio L.	Manila Central University	1956	Madison
Rich, Ciney R.	Northwestern University	1956	Wauwatosa
Schwarzell, John R.	Ohio State University	1965	Wauwatosa
Sipes, Donald R.	University of Missouri	1960	Green Bay
Snider, Alvin B.	University of Texas Southwestern	1963	Sun Prairie
Stevens, Joseph C.	Washington University	1961	Madison
Taebel, Duane	University of Chicago	1960	La Crosse
Thorsen, William	University of Virginia	1960	Madison
Vangor, Donald W.	University of Illinois	1962	Wisconsin Dells
Versaci, Antonio A.	New York University	1949	Chicago, Ill.
Wasick, Milan M.	University of Illinois	1937	Chicago, Ill.
Whittaker, William	Medical College of Virginia	1960	Middleton

The following physicians were granted licenses by oral examination by the State Board of Medical Examiners at a meeting in Milwaukee, July 13, 1966.

Name	*School of Graduation*	*Year*	*City*
Anastasia, Peter J.	Tufts University	1958	Plymouth
Atzeff, Luben	Tulane University	1965	Madison
Baumann, Richard C.	Marquette University	1965	Milwaukee
Beck, John Jay	Northwestern University	1965	Sturgeon Bay
Belson, Thomas P.	Marquette University	1963	Wauwatosa
Benneyan, Robert N.	Cornell University	1958	Fond du Lac
Biddle, Charles M., IV	Temple University	1965	Madison
Bigwood, Gerald F.	University of Bristol	1947	Winona, Minn.
Brusky, John Dean	Marquette University	1963	Madison
Burg, Richard M.	Tulane University	1965	Madison
Burkert, Lawrence B.	Western Reserve University	1965	Milwaukee
Buttles, Anson J.	Marquette University	1965	Milwaukee
Cafaro, John R.	Creighton University	1959	Milwaukee
Cassidy, George E.	Marquette University	1965	Milwaukee
Cooper, Richard	Washington University	1961	Milwaukee
Craig, William	Tufts University	1965	Madison
De Witt, Robert J.	Columbia University	1961	Marinette
DiRaimondo, Joseph C.	Washington University	1965	Madison
Doerscheln, Wilbur J.	University of Illinois	1943	Wilmette, Ill.
Dowd, Frank V.	University of Tennessee	1953	Wood
Eist, Harold I.	University of Alberta	1961	St. Paul, Minn.
Eriksen, David E.	Ohio State University	1965	Brookfield
Fabiny, Robert J.	Western Reserve University	1965	Madison
Faller, William	Northwestern University	1965	Milwaukee
Felion, Paul L.	University of Minnesota	1958	La Crosse
Franzen, Lyle D.	Loyola University	1954	Westfield, N. Y.
Friedrich, Edward G., Jr.	Johns Hopkins University	1963	Milwaukee
Gale, Henry H.	University of British Columbia	1954	Brown Deer
Geiger, Charles S., Jr.	Loyola University	1963	Wauwatosa
Goldstein, Frank P.	University of Western Ontario	1961	Racine
Gordon, Robert P., Jr.	Northwestern University	1958	Marshfield
Grieshop, Joseph L.	Marquette University	1965	Milwaukee
Grubb, William B., Jr.	Washington University	1960	Appleton
Gryniewicz, Michael	Marquette University	1965	Milwaukee
Guillermo, Remedios A.	University of Santo Tomas	1953	Wood
Gustke, Robert F.	West Virginia University	1963	Milwaukee
Gustke, Susan S.	West Virginia University	1964	Milwaukee
Hansen, Robert W.	Marquette University	1965	Wauwatosa
Hansing, Charles E.	University of Pennsylvania	1965	Madison
Hardacre, Jerry M.	Ohio State University	1959	Marshfield
Harrison, Ronald A.	Northwestern University	1965	Brookfield
Haug, Stephen L.	Creighton University	1959	La Crosse
Hendricks, Richard J.	Loyola University	1960	Madison
Hiatt, Christopher L.	Ohio State University	1965	Wauwatosa
Hinson, Robert E.	University of Iowa	1960	Milwaukee
Holzman, Bruce R.	Northwestern University	1965	Madison
Hoose, Kenneth A., Jr.	Emory University	1965	Madison
Howard, Richard S.	University of Pennsylvania	1957	La Crosse

WISCONSIN LICENTIATES *continued*

Name	*School of Graduation*	*Year*	*City*
Huewe, Douglas A.	Marquette University	1965	Milwaukee
Hughes, George R.	New York Medical College	1963	Milwaukee
Hurley, Leonard C.	Loyola University	1953	Elgin, Ill.
Hussussian, Jaeques	University of Alexandria	1955	Lake Forest, Ill.
Janis, Martin	New York University	1963	Madison
Jarrett, John R.	Northwestern University	1965	Wauwatosa
Karos, Michael G.	Marquette University	1962	Milwaukee
Kitzman, Robert H.	Marquette University	1965	Milwaukee
Kontra, Dennis J.	Northwestern University	1965	Milwaukee
Kroner, Thomas C.	St. Louis University	1965	Wauwatosa
La Breche, Michael J.	Marquette University	1965	Madison
Lee, Ernest K. H.	Marquette University	1962	Milwaukee
Lemper, Paul David	University of Pennsylvania	1965	Milwaukee
Levy, Jay M.	Johns Hopkins University	1955	Madison
Lewis, Joseph D.	University of Tennessee	1962	Wauwatosa
Malewiski, Larry J.	University of Wisconsin	1965	Sheboygan
Marks, Morton G.	Rush Medical College	1925	Milwaukee
McFadden, Maureen D.	Western Reserve University	1965	Madison
Melluish, James W.	University of Michigan	1965	West Milwaukee
Miller, Herbert P., Jr.	University of Iowa	1954	Manitowoc
Miller, James D.	Marquette University	1965	Stevens Point
Modjeski, Joseph R.	University of Illinois	1942	Hammond, Ind.
Mohs, Frank R.	St. Louis University	1953	Billings, Mont.
Molloy, Richard P.	Marquette University	1965	Wauwatosa
Moritz, Terrell C.	Northwestern University	1965	Milwaukee
Nathenson, Aarron L.	University of Minnesota	1965	Milwaukee
Nelson, David L.	University of Minnesota	1963	Stoughton
Nichols, Charles P.	Marquette University	1965	Wauwatosa
Norris, Arthur G.	University of Wisconsin	1965	Madison
Olson, Albert P., II	University of Nebraska	1965	Madison
Osborn, June E.	Western Reserve University	1961	Madison
Pawlowski, Gene J.	Marquette University	1965	Milwaukee
Petersen, Roger D.	University of Illinois	1965	Elkhorn
Pfarr, Paul A.	St. Louis University	1954	Arvada, Col.
Place, John S.	Baylor University	1965	Milwaukee
Pois, Allen J.	Tufts University	1957	Madison
Rhomberg, Bernard B.	University of Chicago	1965	Milwaukee
Riddick, Joseph H., Jr.	Duke University	1962	Marshfield
Roekman, Stanley E.	Indiana University	1965	Madison
Rubin, David K.	Johns Hopkins University	1960	Wauwatosa
Sanfelippo, Peter M.	Marquette University	1965	Milwaukee
Schaberl, Karl N.	Loyola University	1965	Milwaukee
Schroeder, Daniel J., Jr.	University of Wisconsin	1965	Amery
Sepp, Ingeborg E.	University of Heidelberg	1960	Milwaukee
Shaw, Donald K.	Marquette University	1965	Milwaukee
Smith, Martin J.	Columbia University	1959	La Crosse
Snider, Gordon L.	University of Toronto	1944	Milwaukee
Stenberg, Clayton C.	Harvard Medical School	1960	Monroe
Stephens, James P.	Indiana University	1959	Sturgeon Bay
Stevens, David A.	University of Rochester	1965	Madison
Stevens, Michael L.	Loyola University	1965	Milwaukee
Stilp, Thomas J.	Marquette University	1965	Milwaukee
Stincheomb, David E.	Ohio State University	1963	Madison
Sullivan, John F.	University of Wisconsin	1961	Appleton
Tankersley, James C.	Harvard Medical School	1960	La Crosse
Thompson, Kenneth W.	Harvard University	1929	Madison
Tobin, Daniel A.	University of Illinois	1944	Madison
Tucker, Kenneth R.	University of Washington	1965	Wauwatosa
Tuffli, Gordon A.	University of Wisconsin	1964	Madison
Vogt, Wess R.	Marquette University	1965	Milwaukee
Von Haam, Emmerich, Jr.	Northwestern University	1965	Wauwatosa
Wadina, Gerald W.	Marquette University	1965	Wauwatosa
Wagner, Stephen F.	University of Wisconsin	1965	Marshfield
Ware, Robert J.	University of Wisconsin	1964	Wauwatosa
Wiegmann, Otto A.	University of Tubingen	1958	Brookfield
Woods, John E.	Western Reserve University	1955	Wauwatosa

The following physicians were granted licenses by oral and written examination by the State Board of Medical Examiners at a meeting in Milwaukee, July 12, 13, 14, 1966.

Name	*School of Graduation*	*Year*	*City*
Adali, Ilhan S.	University of Istanbul	1956	Milwaukee
Ahmed, Saifuddin	University of the Punjab	1946	Ogema
Arjmand, Towfig M.	University of Tehran	1954	Kankakee, Ill.
Beguin, Everett A., Jr.	University of Wisconsin	1965	Rock Hill, Mo.

Name	*School of Graduation*	*Year*	*City*
Buedingen, Richard P.	University of Wisconsin	1965	St. Albans, N. Y.
Carlson, Thomas J.	University of Wisconsin	1965	Tomah
Collopy, Michael C.	Marquette University	1963	Milwaukee
Coron, Alfred J.	University of Wisconsin	1965	Milwaukee
Danocup, Roberto J.	University of Santo Tomas	1957	Milwaukee
Davies, William B.	University of Wisconsin	1965	Waukesha
Davis, Michael A.	University of Wisconsin	1965	Milwaukee
Doty, John W.	University of Wisconsin	1965	Madison
Dutton, Robert C.	University of Wisconsin	1965	Chevy Chase, Md.
Ellis, Robert G.	University of Wisconsin	1965	Pensacola, Fla.
Fischer, Louis C.	University of Wisconsin	1965	Pensacola, Fla.
Fritschel, William G.	University of Wisconsin	1964	Ann Arbor, Mich.
Hagen, Thad C.	University of Wisconsin	1965	Arlington, Va.
Harrington, John T., Jr.	University of Wisconsin	1965	Brookline, Mass.
Hemingway, Dennis L.	University of Wisconsin	1961	Ft. Lewis, Wash.
Hoeper, Edwin W.	Northwestern University	1965	Madison
Hollero, Numeriano J.	University of Santo Tomas	1960	Milwaukee
Holthusen, Gregory G.	University of Wisconsin	1965	Birmingham, Mich.
Ihle, Charles V.	University of Wisconsin	1965	Madison
James, Reese E.	University of Wisconsin	1965	Green Bay
Lee, Chew Yon	Ewha Woman's University	1959	Madison
Mir, Ali A.	Pahlavi University	1959	Two Rivers
Montenegro, Jose V., III	Far Eastern University	1958	Hales Corners
Muth, Donald M.	University of Wisconsin	1965	Milwaukee
Nepomuceno, Ruben A.	University of Santo Tomas	1959	Black Creek
Quitzon, Andres F.	University of Santo Tomas	1955	Milwaukee
Reasa, Douglas A.	University of Wisconsin	1965	Brookfield
Reyes, Jose E., Jr.	Far Eastern University	1959	Kenosha
Santiago, Fernando S.	University of Santo Tomas	1956	Monroe
Schroeder, Gerald H.	University of Wisconsin	1965	Wichita, Kansas
Stinson, H. Keith	University of Manitoba	1957	Marshfield
Straits, Beverly Joan	Northwestern University	1965	Milwaukee
Subapodok, Charungsang	University of Medical Sciences	1960	Milwaukee
Swanson, Priscilla	University of Wisconsin	1965	Chicago, Ill.
Terner, E. Anne	University of Sheffield	1955	Green Bay
Trewartha, Mark	University of Wisconsin	1964	Cross Plains
Vergamini, Jerome C.	University of Wisconsin	1965	Madison
Voss, Dieter M.	Albert Ludwigs University	1958	Marshfield
Zimmerman, Delano E.	University of Wisconsin	1965	Winnebago

The following physicians were granted licenses by oral examination by the State Board of Medical Examiners at a meeting in Madison, October 14, 1966.

Name	*School of Graduation*	*Year*	*City*
Abroms, Gene M.	Harvard Medical School	1959	Madison
Barrett, David A., II	Marquette University	1963	South Milwaukee
Belz, Reinmar H.	University of Erlangen	1952	St. Paul, Minn.
Brown, Edwin M.	University of Vermont	1957	Milwaukee
Brown, James R.	University of Louisville	1958	Eau Claire
Brown, Patricia H.	University of Vermont	1957	Milwaukee
Bruner, Allen M.	University of Illinois	1929	Oconomowoc
Bruns, William C.	University of Iowa	1965	Madison
Camacho, Ernesto M.	Manila Central University	1953	Cambria
Carlson, Haakon P.	University of Wisconsin	1964	Prairie du Sac
Christian, James A.	Meharry Medical College	1965	Milwaukee
Cicciarelli, Francis E.	Loyola University	1959	Dubuque, Iowa
Cornell, John W.	Marquette University	1963	Cudahy
Cullen, Joseph M.	Loyola University	1961	Madison
Daly, Mary Viola	University of Maryland	1955	Wauwatosa
Dean, Alice Rogers	Western Reserve University	1962	Brookfield
Demos, Terrence C.	University of Illinois	1963	Madison
Diefenbach, Eugene J.	University of Minnesota	1949	Minneapolis, Minn.
Ducommun, Dale J.	University of Iowa	1958	Lockport, N.Y.
Dunkelberger, Lawrence	University of Illinois	1963	Madison
Farmer, Charles E., Jr.	University of Mississippi	1959	Butler
Fishburn, Charles W.	University of Colorado	1963	Ann Arbor, Mich.
Gatenby, Arthur E.	University of Illinois	1963	Stoughton
Glynn, Kevin P.	Northwestern University	1961	Ann Arbor, Mich.
Good, Thomas A.	University of Minnesota	1952	Milwaukee
Grossberg, Sidney E.	Emory University	1954	Milwaukee
Harrison, Charles	University of Pittsburgh	1963	Milwaukee
Helm, Frederic C.	University of Illinois	1965	Milwaukee
Hughes, Charles V., Jr.	West Virginia University	1963	Wauwatosa
Jones, William D.	Marquette University	1965	Milwaukee

WISCONSIN LICENTIATES *continued*

Name	*School of Graduation*	*Year*	*City*
Kazamias, Thomas M.	Boston University	1963	Madison
Keller, Meredith E.	University of Texas	1955	Oshkosh
Kinder, Eugene J.	Loyola University	1952	River Forest, Ill.
Krautkramer, Ronald R.	University of Cincinnati	1965	Milwaukee
Kreiter, Richard L.	University of Iowa	1965	La Crosse
Lamar, Carlos, Jr.	Tulane University	1955	Madison
Lane, Larry R.	University of Illinois	1965	Wauwatosa
Litton, Jason J.	State University of New York	1962	Milwaukee
Lyons, Charles S., Sr.	Ohio State University	1941	Oshkosh
Mahairas, Gregory H.	New York Medical College	1959	La Crosse
Maultsby, Maxie C., Jr.	Western Reserve University	1957	Madison
Mercer, Wayne C.	University of Iowa	1952	Ashland
Meyer, Wayne W.	Northwestern University	1965	Milwaukee
Muller, Thomas J.	Creighton University	1962	Madison
Nelson, John W.	Indiana University	1953	Milwaukee
O'Gara, John P.	University of Nebraska	1962	Madison
O'Sullivan, Donal D.	Loyola University	1950	Chicago, Ill.
Owens, Arthur W.	Louisiana State University	1965	Madison
Paget, Edward T.	University of Oregon	1965	Rochester, Minn.
Pfeiffer, Donald W.	University of Iowa	1947	McGregor, Iowa
Pretlow, Thomas G., II	University of Rochester	1965	Madison
Reilly, G. Douglas	University of Michigan	1961	Minneapolis, Minn.
Renick, Charles A.	Harvard Medical School	1936	Madison
Schroeder, Robert W.	University of Wisconsin	1953	Beloit
Sedlack, Richard E.	Northwestern University	1956	Rochester, Minn.
Shealy, C. Norman	Duke University	1956	La Crosse
Shindell, Sidney	State University of New York	1946	Bayside
Skopec, H. Michael	Marquette University	1965	Madison
Sparks, George	University of Illinois	1962	Middleton
Spring, Donald A.	University of Wisconsin	1963	Rochester, Minn.
Sulman, David	State University of New York	1959	Middleton
Tormey, Douglass C.	University of Wisconsin	1964	McFarland
Vakili, Hossein	Tehran Medical School	1944	Medford
Varma, Som D.	Osmania Medical College	1955	New Berlin
Watson, John D.	University of Minnesota	1963	Madison
Yates, Jerome W.	University of Illinois	1965	West Allis
Zizmor, Judah	University of Wisconsin	1934	New York City, N. Y

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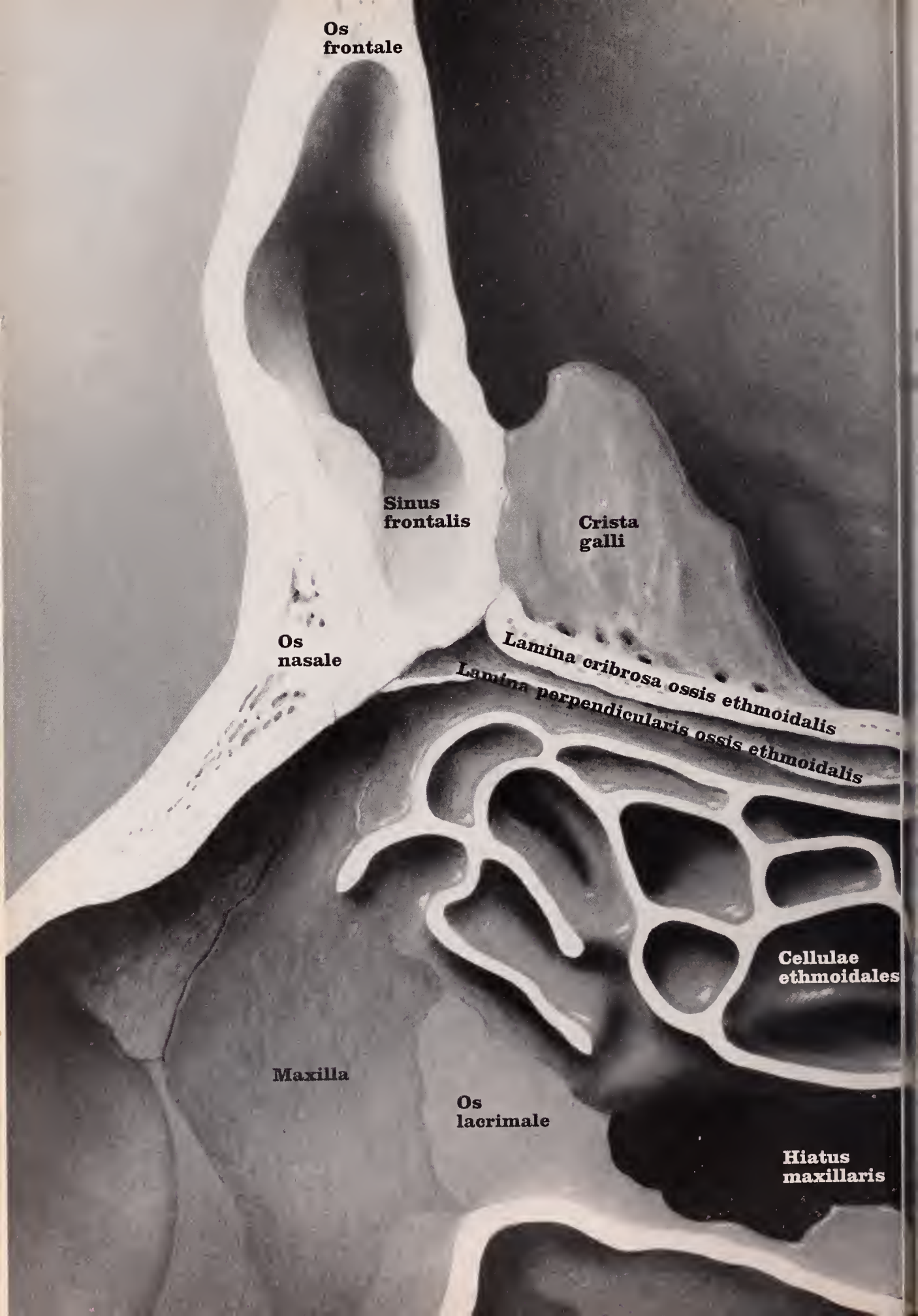
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1967 WISCONSIN

Apr. 5: Fifth annual educational symposium on The Geriatric Patient, sponsored by the State Medical Society of Wisconsin in cooperation with Northwest Psychiatric Clinic, Eau Claire.

Apr. 6–8: Postgraduate conference on "The Mentally Retarded Child," sponsored by the Department of Pediatrics, University of Wisconsin.

Apr. 10–21: Advanced maternity program in delivery room nursing, Marquette University College of Nursing, Milwaukee.

Apr. 12–13: Second annual postgraduate conference on prevention and management of athletic injuries, sponsored by University of Wisconsin Medical Center, Wisconsin Center building, Madison.

May 9–11: State Medical Society annual meeting, Milwaukee.

May 20: Annual meeting, Wisconsin Heart Association, Milwaukee.

Aug. 24–26: Conference on "Current Concepts in Surgery" sponsored by the Department of Surgery, UW Medical Center, at Wisconsin Center, Madison.

Sept. 14: Symposium on stroke, sponsored by the Wisconsin Heart Association and the Adolf Gundersen Medical Foundation, La Crosse.

Oct. 16–20: Wisconsin Work Week of Health, State Medical Society of Wisconsin, Madison.

1967 NEIGHBORING STATES

Apr. 7–8: Postgraduate course in trauma, University of Minnesota, Minneapolis.

Apr. 10–22: Postgraduate course in laryngology and bronchoesophagology, Illinois Eye and Ear Infirmary, Chicago.

Apr. 12: "Endocrines and the Reproductive System," seventh in a series of programs by the University of Chicago Hospitals and Clinics.

Apr. 19–22: 11th Annual Postgraduate Course on Fractures and Other Trauma, sponsored by American College of Surgeons, John B. Murphy Auditorium, Chicago.

Apr. 27–29: Postgraduate course in obstetrics, University of Minnesota, Minneapolis.

May 1–3: 37th Tri-State Hospital Assembly, Chicago.

May 1–3: Postgraduate course in ophthalmology, University of Minnesota, Minneapolis.

May 10: "Head Injuries," eighth in a series of programs by the University of Chicago Hospitals and Clinics.

May 11–13: Fourth Midwest Anesthesiology Conference, sponsored by Illinois Society of Anesthesiologists, The Palmer House, Chicago, Ill.

May 25–27: Postgraduate course in surgery, University of Minnesota, Minneapolis.

June 1–3: Postgraduate course in anesthesiology, University of Minnesota, Minneapolis.

June 12–15: Catholic Hospital Association convention, Chicago.

June 19–21: Postgraduate course in "Clinical Applications—Recent Advances in Pharmacology," presented by the American College of Physicians, at the University of Iowa, Iowa City.

Oct. 2–6: Annual clinical congress, American College of Surgeons, Chicago.

1967 OTHERS

May 3: Scientific session, American Cancer Society, Dallas, Tex.

June 18–22: 116th AMA annual convention, Atlantic City, N.J.

June 18–22: 44th annual convention of the Woman's Auxiliary to the AMA, Atlantic City, N.J.

June 25–July 2: Fifth International Congress of Chemotherapy, Vienna.

June 26–28: Spring Clinics, Children's Hospital, Denver.

July 2–6: European Cancer Meeting, Vienna.

1968 OTHERS

Oct. 21–25: Annual Clinical Congress, American College of Surgeons, Atlantic City, N.J.

For listing of other meetings see the JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION.

MEDICAL MEETINGS

POSTGRADUATE COURSES

Symposium on Geriatric Patient, Eau Claire

An educational symposium on The Geriatric Patient will be held at the Eau Claire Country Club in Eau Claire Wednesday, April 5, under the sponsorship of the State Medical Society's Division on Nervous and Mental Diseases of the Commission on State Departments in cooperation with the Northwest Psychiatric Clinic. The program has been approved by the Commission on Scientific Medicine. It is also supported in part by the Charitable, Educational and Scientific Foundation of the State Medical Society, Wisconsin Psychiatric Institute, Division of Mental Hygiene of the State Department of Public Welfare, Sandoz Laboratories, Ciba Pharmaceuticals, Eli Lilly & Company, Marion Laboratories, McNeil Laboratories, Roche Laboratories, Schering Corp., Postgraduate Program of Merck, Sharp & Dohme, and Smith Kline & French Laboratories.

In presenting a "Profile of the Aged" the program will cover such subjects as The Psychiatric Approach, Neurological Problems in Geriatrics, and The Psychiatric Implications of the Physician's Illness. There will also be a panel of case presentations as well as additional speakers who will cover more aspects of this topic.

Symposium moderator will be Dr. Nolan D. C. Lewis of Frederick, Md. Out-of-state participants include: Dr. Adriaan Verwoerdt, assistant professor of psychiatry and director of the Geropsychiatry Training Program, Duke University Medical Center, Durham, N.C.; Dr. Jesse Barron, specialist in internal medicine, Minneapolis, Minn.; Dr. Edward Litin, head of the Section of Psychiatry, Mayo Clinic, Rochester, Minn.; and Mr. Jule Hannaford, chief legal counsel of the Minnesota State Medical Association.

Speakers from Wisconsin are: Dr. Francis Forster, chairman of the Department of Neurology, University of Wisconsin Medical Center, Madison; Vivian Wood, PhD, University of Wisconsin School of Social Work, Madison; Drs. R. M. Lotz and Peter Midelfart of Eau Claire; Dr. Robert Leasum of Osseo; and Dr. James Maser of Rice Lake.

Joint Conference Clinic Day, Milwaukee

A Joint Conference Clinic Day will be held in Milwaukee April 29 from 9 am to 3 pm at the Red Carpet Inn, 4747 South Howell Avenue (across from General Mitchell Field). Sponsors are four Milwaukee-area hospitals: Trinity Memorial, St. Francis, St. Luke's, and West Allis Memorial.

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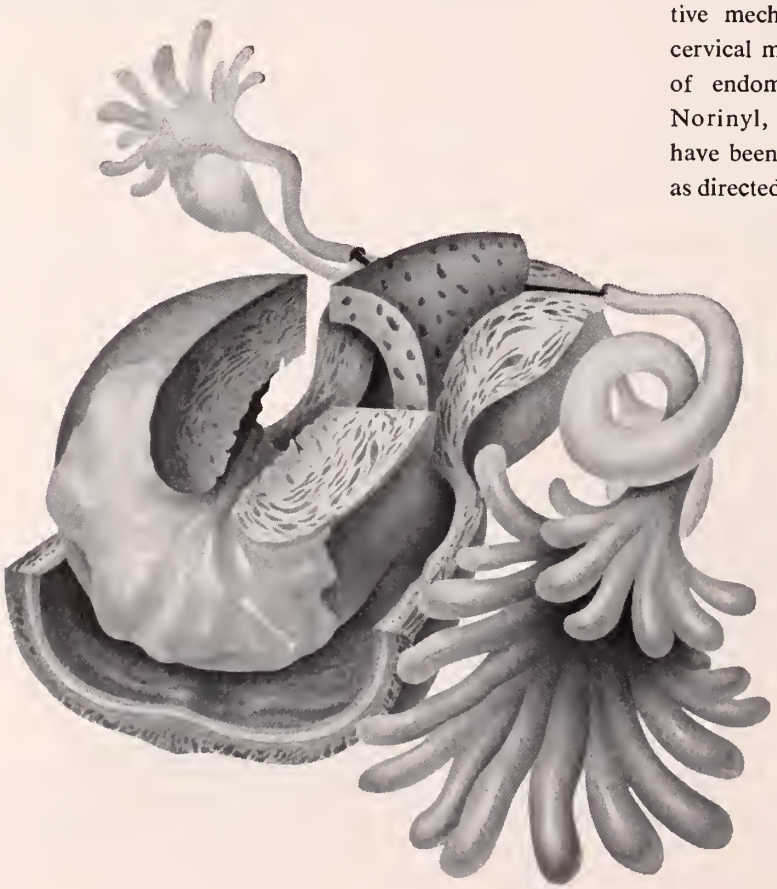

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Contraindications: Thrombophlebitis or pulmonary embolism (current or past). Existing evidence does not support a causal relationship between use of Norinyl and development of thromboembolism. While a study which was conducted does not resolve definitively the possible etiologic relationship between progestational agents and intravascular clotting, it tends to confirm the findings of the Ad Hoc Advisory Committee appointed by the Food and Drug Administration to review this possibility. Cardiac, renal or hepatic dysfunction. Carcinoma of the breast or genital tract. Patients with a history of psychic depression should be carefully studied and the drug discontinued if depression recurs to marked degree. Patients with a history of cerebral vascular accident.

Warning: Discontinue medication pending examination if there is sudden partial or complete loss of vision, or if there is a sudden onset of proptosis, diplopia or migraine. If examination reveals papilledema or retinal vascular lesions, medication should be withdrawn.

Precautions: By May 1963, experience with norethindrone 2 mg.—mestranol 0.1 mg. had extended over 24 months. Through miscalculation, omission or error in taking the recommended dosage of Norinyl, pregnancy may result. If regular menses fail to appear and treatment schedule has not been adhered to, or if patient misses two menstrual periods, possibility of pregnancy should be resolved before resuming Norinyl. If pregnancy is established, Norinyl should be discontinued during period of gestation since virilization of the female fetus has been reported with oral use of progestational agents or estrogen. When lactation is desired, withhold Norinyl until nursing needs are established. Existing uterine fibroids may increase in size. In metabolic or endocrine disorders, careful clinical preevaluation is indicated. A few patients without evidence of hyperthyroidism had elevated serum protein-bound iodine levels, which in the light of present knowledge, does not necessarily imply hyperthyroidism. Protein-bound iodine increased following estrogen administration. Bromsulphalein retention has occurred in up to 25% of patients without evidence of hepatic dysfunction. Studies from 24-hour urine collections have shown an increase in aldosterone and 17-ketosteroids and decrease in 17-hydroxycorticoid levels. Thus, Norinyl should be discontinued prior to and during thyroid, liver or adrenal function tests. Because progestational agents may cause fluid retention, conditions such as epilepsy, migraine and asthma require careful observation. Thus far no deleterious effect on pituitary, ovarian or adrenal function has been noted; however, long-range possible effect on these and other organs must await more prolonged observation. Norinyl should be used with caution in patients with bone, renal or any disease involving calcium or phosphorus metabolism.

Side Effects: Intermenstrual bleeding; amenorrhea; symptoms resembling early pregnancy, such as nausea, breast engorgement or enlargement, chloasma and minor degree of fluid retention (if these should occur and patient has not strictly adhered to medication plan, she should be tested for pregnancy); weight gain; subjective complaints such as headache, dizziness, nervousness, irritability; in a few patients libido was increased. In a total of 3,090 patients, 2.2% discontinued medication because of nausea.

NOTE: See sections on contraindications and precautions for possible side effects on other organ systems.

Dosage and Administration: One Norinyl tablet orally for 20 days, commencing on day 5 through and including day 24 of the menstrual cycle. (Day 1 is the first day of menstrual bleeding.)

Availability: Dispensers of 20 and 60 tablets; bottles of 100.

References: 1. Council on Drugs. JAMA 187:664 (Feb. 29) 1964. 2. Bryans, F. E.: Canad Med Ass J 92:287 (Feb. 6) 1965. 3. Goldzieher, J. W.: Med Clin N Amer 48:529 (Mar.) 1964. 4. Cohen, M. R.: Paper presented at Symposium on Low-Dosage Oral Contraception, Palo Alto, Calif., July 15, 1965. Reported in Med Sci 16:26 (Nov.) 1965. 5. Hammond, D. O.: Ibid. 6. Rice-Wray, E., Goldzieher, J. W., and Aranda-Rosell, A.: Fertil Steril 14:402 (Jul.-Aug.) 1963. 7. Goldzieher, J. W., Moses, L. E., and Ellis, L. T.: JAMA 180:359 (May 5) 1962. 8. Kempers, R. D.: GP 29:88 (Jan.) 1964. 9. Tyler, E. T.: JAMA 187:562 (Feb. 22) 1964. 10. Rudel, H. W., Martinez-Manautou, J., and Maqueo-Topete, M.: Fertil Steril 16:158 (Mar.-Apr.) 1965. 11. Flowers, C. E., Jr.: N Carolina Med J 25:139 (Apr.) 1964. 12. Goldzieher, J. W.: Appl Ther 6:503 (June) 1964. 13. The Control of Fertility. Report adopted by the Committee on Human Reproduction of the American Medical Association. JAMA 194:462 (Oct. 25) 1965. 14. Flowers, C. E., Jr.: JAMA 188:1115 (June 29) 1964. 15. Merritt, R. I.: Appl Ther 6:427 (May) 1964. 16. Newland, D. O.: Paper presented at Symposium on Low-Dosage Oral Contraception, Palo Alto, Calif., July 15, 1965. Reported in Med Sci 16:26 (Nov.) 1965.

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Norinyl® tablets
(norethindrone 2 mg c̄ mestranol 0.1 mg.)

for multiple contraceptive action

Guest speakers and their topics are:

W. NEWLON TAUXE, MD, Chief, Isotope Laboratory, Mayo Clinic, and Associate Professor, Department of Pathology, University of Minnesota Graduate School, Rochester, "Pathology, Surgery and Late Results of Renal Vascular Surgery" and "Newer Developments in Evaluation of Renal Function by Radioactive Isotope Techniques."

JOSEPH H. HOLMES, MD, Professor of Medicine, University of Colorado Medical Center, Denver, "Medical Management of the Uremic Patient."

CONRAD L. PIRANI, MD, Chairman, Department of Pathology, Clinical Professor of Pathology, University of Illinois College of Medicine, Michael Reese Hospital and Medical Center, Chicago, "Contributions of Renal Biopsy and Electromicroscopy to the Understanding of Renal Disease."

DAVID HUME, MD, Professor and Chairman of Department of Surgery, Medical College of Virginia, Richmond, "Current Status of Renal Transplantations."

EUGENE POUTASSE, MD, Norfolk, Va., "Surgery and Pathology of Renal Vascular Disease."

Panel discussion and guest speakers: EDWIN H. ELLISON, MD, Moderator, Professor of Surgery and Chairman of Department of Surgery, Marquette University School of Medicine; and DONALD M. ROTH, MD, Participant, Associate Professor of Medicine, Marquette, Milwaukee.

Chairman of the meeting is Dr. Sherwood Stolp; co-chairman, Dr. Edward C. Saltzstein. The planning committee consists of Drs. Rocco Latorraca, chairman, Theodore H. Borowski, Harold J. Conlon, Merline A. Kottke, Alexander J. MacGinnes, George V. Murphy, Edward C. Saltzstein, and Sherwood Stolp.

The clinic is open to all physicians. A $5.00 registration fee includes lunch. Reservations to: Dr. Sherwood Stolp, 5810 W. Oklahoma Ave., Milwaukee.

American Cancer Society Meeting, Dallas

The 1967 Scientific Session of the American Cancer Society will be held May 3 at the Sheraton–Dallas Hotel, Dallas, Tex. Theme is: Current Concepts in Etiology and Diagnosis of Cancer. Sessions are open to all members of the medical professions and students. No advance registration or registration fee. Inquiries concerning the program should be addressed to: Vice President for Professional Education, ACS, Inc., 219 E. 42nd Street, New York, N. Y. 10017.

AMA 116th Annual Convention

The 116th AMA Annual Convention will be held in Atlantic City, New Jersey, June 18–22, 1967. Convention Hall and surrounding hotels will house the Scientific Program; the House of Delegates will meet at the Chalfonte–Haddon Hall Hotel. A full schedule of medical motion pictures is planned and at least five color telecasts will be broadcast, live from a Philadelphia hospital in cooperation with the University of Pennsylvania School of Medicine.

Patient care, from the standpoint of standard methods as well as research, will be one of four topics presented in general scientific sessions. In addition to the General Sessions, each of the 22 scientific Sections will present scientific programs. Many of the Section programs will, as in past years, be joint meetings of two or more Sections and, in some instances a specialty society. Specialty societies joining AMA Sections will include: The American College of Chest Physicians, which will join the Section on Diseases of the Chest for a program; The American College of Cardiology, who joins the Section on Internal Medicine and The Society for Investigative Dermatology, Inc., which will hold its meetings in conjunction with the Section on Dermatology.

Woman's Auxiliary to AMA Meeting

Mary Calderone, M.D., noted proponent of sex education, will be one of the speakers at the 44th Annual Convention of the Woman's Auxiliary to the AMA, June 18–22, in Atlantic City. Convention headquarters will be the Shelburne Hotel.

Doctor Calderone's talk is scheduled for Tuesday morning, June 20, according to Mrs. Asher Yaguda, Newark, New Jersey, Auxiliary president. Also speaking on Tuesday will be Charles L. Hudson, M.D., AMA president.

Mrs. Yaguda and Mrs. Karl F. Ritter, Lima, Ohio, president-elect, will be honored at a reception Sunday, June 18. Mrs. Ritter will be installed as president Wednesday, June 21.

Endocrines and the Reproductive System

The seventh of a series of lectures, called "Frontiers of Medicine," will be held April 12 at The University of Chicago Hospitals and Clinics. This lecture is entitled "Endocrines and the Reproductive System." Coordinators are Drs. Richard L. Landau and Frederick P. Zuspan.

For further information: Miss Dorothy Taylor, Office of the Dean, Division of the Biological Sciences, The University of Chicago, Chicago, Ill. 60637. Telephone: MU 4–6100, ext. 5106.

Tri-State Hospital Assembly

The 37th annual Tri-State Hospital Assembly will be held May 1–3 at the Palmer House in Chicago. Theme of the conference is: Challenges, Channels, and Changes.

Seminars will be held each day with recognized authorities who will participate in a continuing panel exchange focusing on a specific problem area such as: Areawide Planning, Hospital Facilities Planning, and Hospitals and the Law.

The list of speakers includes Dr. John S. Hirschboeck of Milwaukee, regional program coordinator of the Wisconsin Regional Medical Program.

Advance registration information may be obtained from the Tri-State Hospital Assembly, 400 N. Michigan Ave., Chicago, Ill. 60611.

Doctors Receive Blue Shield Service Award Pins

A Blue Shield emblem service pin was awarded to 14 physicians in recognition of their years of service as members of the Commission on Medical Care Plans, the Blue Shield advisory committee which directs the operation of Wisconsin Physicians Service, the insurance program of the State Medical Society of Wisconsin.

The awards were presented by C. H. Crownhart, secretary and general manager of the State Medical Society, at the Commission meeting on February 11–12 at Society headquarters in Madison.

Those present to receive the awards were: *Dr. Robert Krohn* of Black River Falls who received the pin with a diamond inset for 25 years; *Dr. E. M. Dessloch* of Prairie du Chien, a sapphire inset for more than 20 years; *Drs. John T. Sprague* and *C. O. Vingom* of Madison, a ruby inset for 15 or more years; *Drs. M. D. Davis* of Milton, *D. N. Goldstein* of Kenosha, and *F. H. Wolf* of La Crosse, for 10 or more years; and *Drs. J. H. Houghton* of Wisconsin Dells, *D. A. Jeffries* of Shawano, and *Howard Mauthe* of Fond du Lac, for 5 years or more.

Those not present who also received the awards are: *Dr. G. W. Carlson* of Appleton, 20 years; *Dr. R. M. Moore* of Frederic, 15 or more years; and *Drs. A. W. Hilker* of Eau Claire and *A. J. McCarey* of Green Bay, 10 or more years.

The Society's full insurance program as it is now constructed was authorized by its House of Delegates in 1946, and was named Wisconsin Physicians Service. In 1950, the Commission on Medical Care Plans was organized to succeed a group of committees variously associated with the insurance program. Members of the Commission were appointed in 1951, with Dr. E. M. Dessloch of Prairie du Chien named as chairman, a position he still holds. There are presently 23 members of the Commission, plus the Society President and President-Elect as ex officio members. Members of the Commission are appointed by the Chairman of the Council and serve for three-year terms.

Wisconsin Physicians Service policies cover about 413,000 Wisconsin residents and WPS also is carrier for about 315,000 Medicare Part B beneficiaries and 125,000 recipients under the Wisconsin Medical Assistance Program.

Medical Assistants Hold Educational Symposium

Telephones, personnel problems, Medicare, and medical terminology were subjects discussed at the eighth educational symposium of the Wisconsin State Medical Assistants Society, held February 4 at State Medical Society headquarters in Madison. There were 224 persons registered for the all-day session.

Welcoming speeches were given by Mrs. Vera Erdman, president of the WSMAS and *Dr. M. D. Davis* of Milton, WSMAS advisor. Invocation was given by Mrs. Mildred Gedakovitz and the Pledge of Allegiance by Mrs. June Gillette.

Miss Lois Pluckham of Minneapolis, Minn., presented "The AAMA Story," a representative of the Wisconsin Telephone Company discussed "Telephone

A NEAR CAPACITY CROWD of 224 registered members of the Wisconsin State Medicol Assistants Sociey attended the all-day educational symposium, held in the Presidents Room of the State Medical Society heodquarters in Madisan.

DISCUSSING PLANS FOR THE PROGRAM of the Wisconsin State Medical Assistants Society sympasium are, left to right: Mrs. Mildred Gedakovitz; Dr. M. D. Dovis, WSMAS odvisor; Mrs. Audrey Matthews, program chairman; and Mrs. Vera Erdman, WSMAS president.

Advances." "Personnel Problems" were discussed by William Matthews of the Marshfield Clinic. Following a catered lunch a panel discussion on "Medicare" was moderated by Mrs. Aleen Piepenburg, business administrator for Associated University Physicians, University Hospitals, Madison. Panel members were M. A. Christensen, executive assistant to the Director of Medicare Claims, Wisconsin Physicians Service, the insurance division of the State Medical Society of Wisconsin, *Dr. Norman Clausen* of the Quisling Clinic, Madison; and Miss Ellen Kilawee, assistant claims manager of the Social Security Administration office in Madison.

Prof. Herbert M. Howe of the University of Wisconsin gave the final presentation on "Medical Terminology."

MEETINGS AND SPECIAL EVENTS HELD AT THE STATE MEDICAL SOCIETY "HOME" DURING THE MONTH OF FEBRUARY 1967

2 Executive Board, Wisconsin Health Council
4 Wisconsin State Medical Assistants Society Symposium
5 Board of Directors, Wisconsin State Medical Assistants Society
7 Board of Trustees, Dane County Medical Society
7 Madison Urological Society
7 Madison Anesthesiology Society
8 University of Wisconsin "In Depth" Scientific Program
8 Division on Safe Transportation
9 Executive Committee, Commission on Public Policy
10 Commission on Scientific Medicine
11 Commission on Medical Care Plans
12 Commission on Medical Care Plans
13 Insurance Advisory Committee, Dane County Medical Society
19 Wisconsin Chapter, National Multiple Sclerosis Society
21 Program Committee, Wisconsin Health Council
21 Coding Committee, State Clinic Managers Association
22 Council, University of Wisconsin Chapter of Student American Medical Association
22 Subcommittee, Commission on Scientific Medicine

Meetings not held in the Society "Home" but have a direct relationship are printed in italics, with the location in parentheses.

New Materials on Heart Resuscitation Available from Heart Associations

Continuing its program of professional education in the closed chest technique for cardiopulmonary resuscitation (CPR), the American Heart Association and its affiliates have issued new materials in this area as follows:

1: Reprinted an article from the *Journal of the American Medical Association* summarizing the recommendations of a 1966 CPR Conference concerning standardized techniques in performing CPR, training and retraining requirements of personnel and designation of categories of personnel to be taught CPR techniques.

2: Initiated a newsletter, *Cardiopulmonay Resuscitation—Reviews and News,* which briefly reviews articles in professional journals on CPR and related subjects. Of special interest to hospital CPR committees and resuscitation teams, the newsletter will be published about three times yearly by AEH's Committee on Cardiopulmonary Resuscitation. Dr. John J. Schrogie is editor.

3: Published a pamphlet, "Cardiopulmonary Resuscitation—Closed Chest Method" which lists a variety of booklets, slide sets, films and other materials available from Heart Associations to aid in teaching CPR techniques.

4: Prepared two sets of table-top displays to be used at professional meetings which involve physicians, nurses, hospital administrators and dentists. One of the four-panel color displays, entitled "Essentials for Success in Cardiopulmonary Resuscitation," points out the steps necessary for success in emergency CPR, such as prompt recognition of cardiac arrest, immediate action, and well-trained personnel. The second display, "A Hospital Based CPR Program: Emergency Resuscitation Team," directed primarily at hospitals, stresses the importance of having an emergency resuscitation team, as well as a community plan for resuscitation and an adequate training program.

Materials listed in Items 1, 2, and 4 are obtainable only through the AHA National Office. Item 3 may be obtained from the Wisconsin Heart Association, 205 W. Highland Ave., Milwaukee, Wis. 53203.

NEWS OF WISCONSIN PHYSICIANS

Dr. Szweda to College of Physicians

Dr. J. A. Szweda, Beaver Dam, has been elected as a fellow to the American College of Physicians. He is only the second physician in Wisconsin to be elected to the college this year. He graduated from Loyola University Medical School in 1952 and interned at Milwaukee County Hospital in 1952 and 1953.

Dr. Ryan Speaks on Sports Injuries

Dr. Allan J. Ryan, team physician for all University of Wisconsin athletic squads and a noted authority on athletic injuries, spoke on the "Prevention of Recreational Injuries in Sports," at the Kenosha Center on February 8. Doctor Ryan, who was a middle distance and cross country runner at Yale, wrote the book "Medical Care of the Athlete" which was published in 1961. He is an associate professor of physical education, clinical assistant professor of surgery and a staff member of University Hospitals in Madison.

Dr. Stephan Epstein Honored

Dr. Stephan Epstein, Madison, retired member of the Marshfield Clinic and key figure in the formation of the Marshfield Clinic Foundation for Medical Research and Education, was honored at the Clinic's annual meeting in January. Doctor Epstein was the first president of the Clinic and left two years ago to engage in private practice and teaching in Madison.

Dr. Aquino Opens Practice in Monticello

Dr. E. C. Aquino, of Manila, the Philippines, opened his practice recently in Monticello. Doctor Aquino, was graduated from the University of Santo Tomas in Manila in 1959 and in 1960 came to Milwaukee where he served his internship at Deaconess Hospital, followed by two years residency. He also served two years of residency at Omaha, Nebr., specializing in surgery. His wife, Nancy, a registered nurse, is a native of Monticello.

Dr. Samp Leads Discussion on Smoking

Dr. Robert J. Samp, Madison, led a panel of medical researchers and specialists who discussed the problems of smoking and its relationship to diseases at a "Meet the Press" conference on the Madison University Campus. The guests included Junior and Senior high school newspaper editors and staff members from Madison and Dane County.

UW Doctors Accept Grants

Dr. Peter L. Eichman, dean of the University of Wisconsin Medical School accepted a grant of $24,-662 for medical library resources support for 1967 and Allan P. Mackenzie, Ph.D., of the American Foundation for Biological Research, accepted $33,-886 for Public Health Service.

Physicians whose names appear in italics are members of the State Medical Society.

Dr. Dedmon Addresses Woman's Club

"How to Keep Your Husband Alive" was the subject of a talk given by *Dr. Robert E. Dedmon* of Neenah recently before members of the Neenah–Menasha Junior Woman's club.

Dr. Marvin Parker Featured Speaker

Dr. Marvin G. Parker, hematologist at the Racine Medical Center, was the featured speaker at a recent meeting of the Wisconsin Association of Medical Technologists, Racine–Kenosha district.

Dr. S. Marshall Cushman Leaves Racine

Dr. S. Marshall Cushman, Racine, will take a three-year leave to study neurosurgery at Loyola University Medical School. He plans to return to Racine on completion of his studies. While in Racine, he was associated with *Dr. Louis E. Fazen.*

Dr. Mahmood Mirhoseini Leaves Medford

Dr. Mahmood Mirhoseini of Medford is leaving to take a year of study in chest and heart surgery at Marquette University. Doctor Mirhoseini plans on returning to the Medford area on completion of his studies.

Dr. Rian Opens Office in Sturgeon Bay

Dr. Oliver Rian opened an office in Sturgeon Bay recently. His practice is limited to diseases of the skin. Doctor Rian graduated from Marquette University School of Medicine and did his residency at the University of Illinois Research Hospital and worked at the Northwestern University Medical School for three years.

Kenosha Physicians on Smoking Panel

Dr. Louis Olsman, Dr. Michael Miller, Dr. Stephen Holt, and *Dr. William H. Lipman*, were members of a discussion panel on the hazards of smoking held in February at the Kenosha Memorial Hospital.

St. Mary's Names Chief-of-Staff

Dr. George C. Hank, has been named chief-of-staff for 1967 at St. Mary's Hospital in Madison. Other staff officers are *Drs. Arthur M. Sonneland*, vice-chief-of-staff; *Mark F. Backs*, secretary-treasurer and *Robin Allin*, public relations. Department chiefs named were *Drs. John P. Rahm*, surgery; *William Rock*, medicine, *William C. Mussey*, obstetrics and gynecology; *William H. Bartlett*, pediatrics; *James N. Moore*, general practice; *Philip A.*

Hoffman, anesthesia; *Edward M. Burns*, psychiatry; *Dean M. Connors*, pathology, and *O. Arthur Stiennon*, radiology.

Dr. Frank Ziehl Reelected

Dr. Frank Ziehl has been reelected chief-of-staff of St. Anthony hospital, Elm Grove. Other officers reelected are *Dr. J. P. Fetherston*, vice-president; and *Dr. W. E. Feierstein*, secretary-treasurer. *Dr. Thomas Lipscomb*, radiologist, remains chairman of the executive committee.

Dr. Simenstad at AMA Meeting Abroad

Photo courtesy JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION

DR. L. O. SIMENSTAD of Osceola, a member of the Board of Trustees of the American Medical Association and member of Joint Commission on Accreditation of Hospitals, was a part of the delegation who recently attended the World Medical Association Assembly in Manila, the Philippine Islands. From left to right: Doctor Simenstad; Leo E. Brown, assistant to the executive vice-president of the AMA; Dr. G. D. Dorman, secretary–treasurer of the AMA and secretary of the Board of Trustees; and Dr. C. L. Hudson, president of the AMA. A report of the AMA delegation activities in Southeast Asia at the time of this meeting appears in the January 2 issue of JAMA, at page 111/53.

Waukesha Doctor Tells of Historic Operation

Dr. Alfred E. Kritter, assistant clinical professor of orthopedic surgery at Marquette University's medical school, recently addressed the American Academy of Orthopedic Surgeons at San Francisco, Calif. Doctor Kritter, along with his colleagues, *Drs. Owen E. Miller* and *Charles A. Desch* of Waukesha, last month fitted an upper arm prosthesis to a 19-year-old woman whose right arm had been amputated above the elbow. The operation which was successful made medical history in the U. S. Doctor Kritter also addressed a national conference at the Northwestern University Medical School, Evanston, Ill., recently.

Dr. Moody Retires at Pureair, Bayfield

Dr. L. W. Moody recently retired as the superintendent and medical director of Pureair Sanatorium in Bayfield. He received the WATA Distinguished Service Award in 1963 and is a former president of both the Wisconsin and Mississippi Valley Thoracic Societies. *Dr. John Telford* is the new medical director.

Doctor Named to Committee

Dr. A. H. Stahmer, Wausau, has been appointed to a one-year term on the Finance committee of the American Academy of General Practice, headquartered in Kansas City.

Dr. Lewis Reelected Head of Marshfield Clinic

Dr. R. F. Lewis was reelected president of the Marshfield Clinic at the annual meeting held recently. *Dr. Ben Lawton* was reelected vice-president, *Dr. Donald Pederson* was reelected secretary, and *Dr. George Griese* was elected treasurer. Others named to the executive committee were *Dr. William Dovenbarger*, *Dr. Nelson Moffatt*, and *Dr. Joseph Ousley*. Named to the salary committee was *Dr. John Rupel*, and *Dr. Richard Rowe* was elected trustee of the employe retirement plan.

Medical Assistants Hear Dr. Geldner

Dr. Michael M. Geldner, Neenah, recently was the guest speaker at the Outagamie County Medical Assistants meeting held at the Appleton Memorial Hospital. Doctor Geldner related his experiences of the four years he spent in a Russian concentration camp in Siberia. He began studying medicine in 1940 at the University of Warsaw, Poland, and finished in 1950. He did five years of residency work at a Warsaw hospital and also spent two more years in the department of neurology there. In 1963 he became a member of the neurology department at New York University, New York City. He has been in the midwest for the past two years.

St. Luke's Staff Elects Department Heads

Dr. J. R. O'Connell, Wauwatosa, chief of the department of internal medicine, and *Dr. Robert J. Fritz*, Hales Corners, chief of the obstetrics and gynecology department, were recently elected as the new department heads at St. Luke's Hospital in Milwaukee. *Dr. F. X. Schuler*, West Milwaukee, was reelected chief of the department of anesthesiology.

Dr. Johnston Heads Staff at Bellin

Dr. Robert Johnston has been elected president of the Bellin Memorial Hospital medical staff for the 1967 term. Other officers are *Dr. Thomas Beno*, secretary; *Dr. Jeremy Green*, chief, department of medicine; *Dr. Orris Keiser*, chief, general practice, *Dr. John Boersma*, chief, obstetrics–gynecology; *Dr.*

Wesley McNeal, chief, pediatrics; and *Dr. Harry Danaher*, chief, surgery. *Dr. Henry Rahr* and *Dr. Peter Groessl* are representatives of general practice.

New Medical Clinic in Superior

Drs. James P. McGinnis, Louis R. Rosin, C. M. Scott and *Robert Sellers*, will be moving into their new medical clinic in April. The clinic will consist of a swimming pool and Sauna bath facility in addition to an area for an emergency surgery room, x-ray equipment, a reception section, and office quarters for the doctors.

Dr. Thomas Meyer Opens Heart Fund Campaign

Dr. Thomas Meyer, assistant dean of the medical school at the University of Wisconsin and 1967 Heart Fund chairman, recently addressed campaign leaders simultaneously via a new telephone system which was set up for the campaign. Speaking from Fond du Lac was *Dr. Hugh J. McLane*, president of the Wisconsin Heart Association. Doctors Meyer and McLane spoke in behalf of the Sheboygan Heart Fund campaign.

Dr. Porter Shows Reproduction Film

Dr. Gerald E. Porter, pediatrician at the Marshfield Clinic, recently presented the American Medical Association film, "Human Reproduction," to a group of parents of eighth grade boys and girls of parochial schools in the Marshfield area.

Dr. Dibble Relates East African Experience

Dr. J. B. Dibble, Eau Claire, who practiced medicine for a year in East Africa, related his experiences to a group of interested persons at the Asbury School of Missions in Asbury Methodist Church, La Crosse, recently.

Colby Clinic Has New Doctor

Dr. Henry S. Waters has become associated with the Colby Clinic for the practice of medicine and surgery. Doctor Waters is a graduate of Columbia Medical School of Physicians and Surgeons, Columbia University, Columbia, N. Y. He served as a medical director of the Iloilo Mission Hospital, Iloilo, the Philippine Islands, and spent ten years as a surgeon with the Foster–Hatch medical group, Pennyan, New York. For the past seven years, he has resided at Marshfield, being associated with the Paul F. Doege Medical Center.

Jefferson Doctor Heads Heart Drive

Dr. C. E. Quandt, Jefferson, recently accepted the chairmanship of the local "Pass the Heart" fund drive for the 1967 Heart Fund campaign in Jefferson.

Dr. Weygandt on Panel in Milwaukee

Dr. James L. Weygandt, Sheboygan Falls, was recently on a panel discussion on problems of drinking and driving at the annual Mid-Winter Safety Conference and Exposition held in Milwaukee.

What can be done for Susan Jane To stop the runs and crampy pain?

Parepectolin for quick relief of acute diarrhea
...soothes colicky pain with paregoric
...consolidates fluid stools with pectin
...adsorbs irritants with kaolin, and protects intestinal mucosa.

In children, Parepectolin may be used to control diarrhea promptly and prevent dehydration, until etiology has been determined. In some cases, Parepectolin may be all the therapy necessary.

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Each fluid ounce of creamy white suspension contains:
Paregoric (equivalent).....(1.0 dram) 3.7 ml.
Contains opium (¼ grain) 15 mg. per fluid ounce.
warning: may be habit forming
Pectin ..... (2½ grains) 162 mg.
Kaolin (specially purified)....(85 grains) 5.5 Gm.
(alcohol 0.69%)
Usual Children's Dose: One or two teaspoonfuls three times daily.

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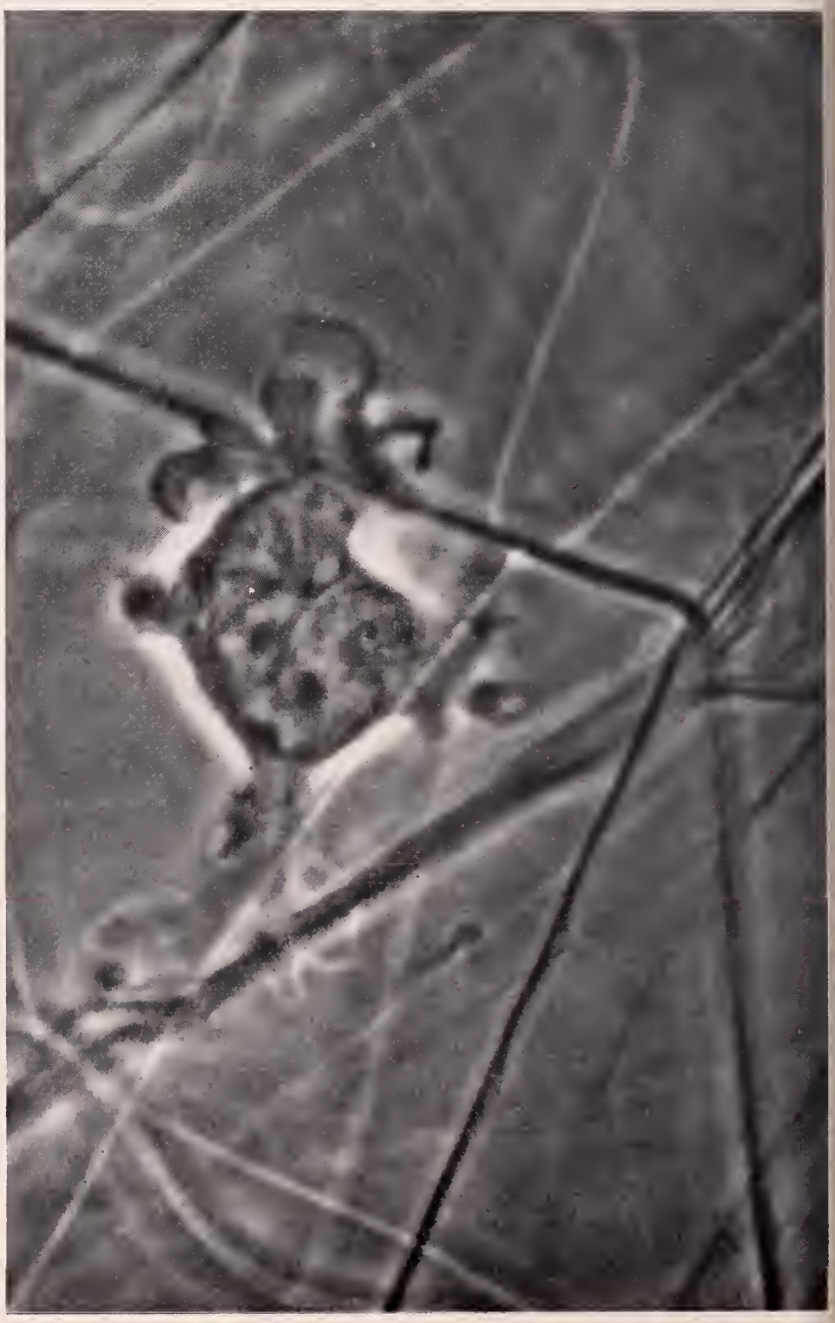
Fort Washington, Pa.

INFLAMMATION: A cellular fight for life

A SYNTEX REPORT based on recently developed hypotheses about topical corticosteroids, including the cellular theories of inflammation by Thomas F. Dougherty, Ph.D., University of Utah.

You are looking at a fibroblast fighting for life. This cell—one of the most common found in connective tissue—has literally been poisoned by cytotoxins released from other cells that have ruptured. Soon, if the abnormal activity of this fibroblast does not cease, it, too, will rupture and die—one more casualty in the inflammatory wave of destruction precipitated by injury.

Until a short time ago no one had ever witnessed such a scene at the cellular level. Now, through advanced cinemicrographic techniques, it is possible to view and photograph the inflammatory process as produced experimentally in living animal tissue. This method permits new insight into the mechanism of inflammation and the role of corticosteroids in therapeutic management. Equally important, these techniques shed new light on factors that may make one corticosteroid more effective than another—factors that can be correlated with other chemical, biologic, and clinical parameters.



Worldwide clinical experience confirms the predictable therapeutic potential of Synalar

It is particularly gratifying that the promise of the advanced chemical design and high order of bioassay activity of Synalar (fluocinolone acetonide) has been confirmed by widespread therapeutic application. Indeed, the impressive clinical response rate of Synalar has been documented in no fewer than 232 papers from 22 countries.

Representative Clinical Results with Synalar*

Efficacy Documented in over 4,000 Patients

Condition	Number of Publications	Number of Patients	Significant Improvement†
Contact Dermatitis	27	750	713
Eczematous Dermatitis	21	472	409
Seborrheic Dermatitis	18	442	426
Atopic Dermatitis	24	460	426
Psoriasis	36	1,699	1,510
Neurodermatitis	18	351	324
Total	144	4,174	3,808

*Complete bibliography on request.

†Expressed by the authors as excellent, very good, good, complete remission of inflammation, etc.

PRESCRIBING INFORMATION

For initiation of therapy: Cream 0.025%, 5 and 15 Gm. tubes, 425 Gm. jars; *for emollient effect:* Ointment 0.025%, 15 Gm. tubes; *for maintenance therapy:* Cream 0.01%, 15 and 45 Gm. tubes, 120 Gm. jars; *for intertriginous or hairy sites:* Solution 0.01%, 20 cc. and 60 cc. plastic squeeze bottles; *for infected inflammatory dermatoses:* Neo-Synalar® Cream (0.025% fluocinolone acetonide, neomycin sulfate, equivalent to 0.35% neomycin base), 5 and 15 Gm. tubes.

CONTRAINDICATIONS: Tuberculous, fungal, and most viral lesions of the skin, (including herpes simplex, vaccinia, and varicella). Not for ophthalmic use. Contraindicated in individuals with a history of hypersensitivity to any of the components. PRECAUTIONS: Synalar preparations are virtually nonsensitizing and nonirritating. However, the solution may produce burning or stinging when applied to denuded or fissured areas. In some patients with dry lesions, the solution may increase dryness, scaling or itching. While topical steroids have not been reported to have an adverse effect on pregnancy, the safety of their use on pregnant females has not absolutely been established. Therefore, they should not be used extensively on pregnant patients, in large amounts, or for prolonged periods of time. Prolonged use of any antibiotic may result in overgrowth of nonsusceptible organisms; if this occurs, appropriate therapy should be instituted. When severe local infection or systemic infection exists, the use of systemic antibiotics should be considered, based on susceptibility testing. SIDE EFFECTS: Side effects are not ordinarily encountered with topically applied corticosteroids. As with all drugs, however, a few patients may react unfavorably to Synalar under certain conditions. The neomycin in Neo-Synalar Cream rarely produces allergic reactions.

REFERENCES: 1. Lerner, L. J., Bianchi, A., Turkheimer, A. R., Singer, F. M., and Borman, A.: Anti-inflammatory steroids: potency, duration and modification of activities. Ann NY Acad Sci 116:1071 (Aug. 27) 1964. 2. Idem: Comparison of anti-granuloma, thymolytic and glucocorticoid activities of anti-inflammatory steroids. Proc Soc Exp Biol Med 116:385 (June) 1964. 3. Ringler, A.: Activities of adrenocorticosteroids in experimental animals and man, in Dorfman, R. I.: Methods of hormone research, New York, Academic Press, 1964. vol. III. pp. 234-280. 4. Gubersky, V. R.: To be published.

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For inflammatory dermatoses... by any measure a topical corticosteroid of choice

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Milligram for milligram one of the most active topical corticosteroids available

Rapid and predictable in antiinflammatory and antipruritic activity

Results often comparable to those of systemic corticosteroids with fewer hazards

PHYSICIAN NEWS *continued*

Appointment for Doctor Ellison

Dr. Edwin H. Ellison, Professor and Chairman of the Division of Surgery at Marquette University School of Medicine, has been appointed to the "Committee on Surgical Education in Medical Schools." The committee functions under the American College of Surgeons and appointments are made by the chairman of its Board of Regents.

The committee is charged with keeping the membership of the American College of Surgeons informed on the various aspects of surgical training in medical schools.

Among points to be considered by the committee are: how to give every medical student the opportunity to know enough about surgery and its subspecialties to select a field of specialization; how to provide courses appropriate for the student who intends to specialize in surgery; how to better inculcate principals of practice and ethics during medical school years.

Dr. Robert E. O'Connor Gives Lecture

Dr. Robert E. O'Connor, superintendent of the Wisconsin Diagnostic Center of the State Department of Public Welfare, recently gave a lecture on "State Planning for Care of Disturbed Children" at Wingspread in Racine. Doctor O'Connor is a 1946 graduate of Marquette University Medical School and interned at New Rochelle Hospital in New York. He is also the co-author of a book entitled "Sex Guidance for your Child."

Dr. Harold E. Cook Ends Retirement

Dr. Harold E. Cook, who retired last November as director of medical services for Milwaukee county institutions and departments, has been appointed medical director of Curative Workshop of Milwaukee, Inc. In his new post, Doctor Cook will direct medical activities of the workshop's four divisions. Doctor Cook resides at Wind Lake and before retirement he had served in county institution medical service for 36 years.

Dr. Vedder Second Mission on SS Hope

Dr. James S. Vedder, pediatrician with the Marshfield Clinic, is planning his second tour of duty aboard the SS HOPE, bound for Colombia. He served on a similar stint with Project Hope in 1962 when the hospital ship went to Peru. *Dr. Robert G. Wochos*, Green Bay, a specialist in general surgery was on board for South America and will be serving for two months on the "rotating" staff.

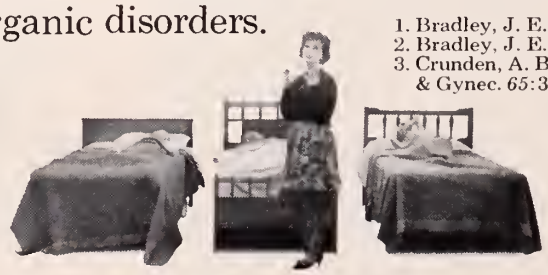
Service Awards of the VA Hospital

Dr. Richard Wasserburger and *Dr. Margaret C. Winston*, Madison, recently received their 20- and 10-year service awards respectively from the Veterans Administration Hospital in Madison.

Togetherness....

...can be rough when epidemics of nausea and vomiting strike a family. Emetrol offers prompt, safe relief. It is free from toxicity[1] or side effects[2,3] and will not mask symptoms of serious organic disorders.

1. Bradley, J. E., *et al.*: J. Pediat. *38*:41 (Jan.) 1951.
2. Bradley, J. E.: Mod. Med. *20*:71 (Oct. 15) 1952.
3. Crunden, A. B., Jr., and Davis, W. A.: Am. J. Obst. & Gynec. *65*:311 (Feb.) 1953.



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phosphorated carbohydrate solution
emesis control

Racine Doctor Heads United Services

Dr. Arthur B. Grant, Racine obstetrician and gynecologist, was recently elected president of Racine's United Community Services.

Dr. Smiley Elected Chairman

Dr. Glenn A. Smiley, Delavan, was recently elected chairman of the Wisconsin Inter-Agency Council on Smoking and Health, it was announced by State Health Officer, *Dr. E. H. Jorris.* Doctor Smiley is chairman of the Medical and Scientific Committee of the American Cancer Society, Wisconsin Division.

Dr. Schott Guest Speaker

Dr. Edward Schott, ophthalmologist with the Sheboygan Clinic, was recently a guest speaker and discussion leader at a meeting of the Sheboygan County Nurses Association. The discussion centered around diseases of the eye, with special emphasis on glaucoma.

Dr. Zarem Named to Counseling Center

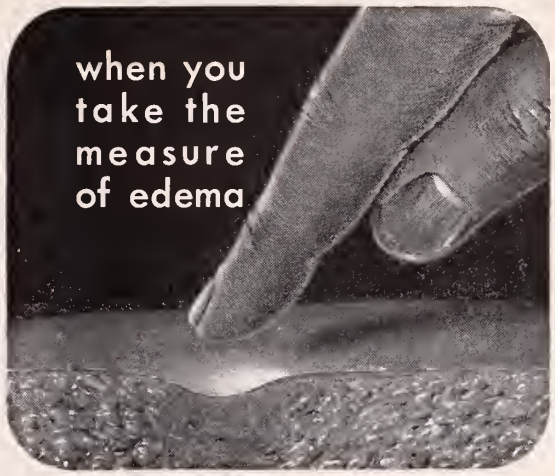
Dr. Norton Zarem, psychiatrist, is a new staff member at the Counseling Center of Sauk, Juneau, and Richland counties. He currently resides in Madison, and also serves in the capacity of chief resident of the outpatient psychiatric services at University Hospitals, Madison. Doctor Zarem is also a member of the faculty in training students in psychiatry at the University of Wisconsin.

Dr. Bernhard Discusses Strokes

Dr. Victor Bernhard, surgeon at Milwaukee County Hospital and a faculty member of Marquette University medical school, recently discussed stroke with the nurses and nursing home personnel at the Manitowoc County courthouse. Doctor Bernhard has done considerable work with Dr. Michael De Bakey, famed cardiovascular surgeon.

Dr. Harkness New Assistant Dean, Marquette

Dr. Gerald A. Kerrigan, dean of the Marquette medical school recently announced the appointment of *Dr. John W. Harkness* as the new assistant dean of the medical school. Doctor Harkness is a pediatrician. He has practiced in Milwaukee for 13 years, except for a two-year leave of absence in 1962–1964 when he was chief medical officer for the Peace Corps in the Philippines. Doctor Harkness received both his B.A. in 1945 and M.D., in 1947 from the University of California. His internship in straight pediatrics was taken at the University of California Medical Center, San Francisco, in 1947–1948, and his residency in pediatrics and traineeship in child psychiatry were taken at Milwaukee Children's Hospital. Doctor Harkness belongs to the American Academy of Pediatrics, and he is vice-president of the Milwaukee Pediatric Society.



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AQUATAG (Benzthiazide) is a potent, orally active, nonmercurial, diuretic agent. It is effective orally in producing diuresis in edema states, where it is therapeutically comparable to mercurials given parenterally. AQUATAG (Benzthiazide) is mildly antihypertensive in its own right and enhances the action of other antihypertensive drugs when used in combination.

DIURETIC ACTION: Clinically, the oral administration of AQUATAG (benzthiazide) results in diuretic activity within two hours with maximal natriuretic, chloruretic, and diuretic effects occurring during the fourth, fifth and sixth hours. Maintenance of response continues for approximately 12 to 18 hours. Acidosis is an unlikely complication since therapeutic doses of AQUATAG (benzthiazide) do not appreciably increase bicarbonate excretion. Edematous patients receiving 50 mg. of AQUATAG (benzthiazide) daily for five days developed a maximal increase in the rate of sodium excretion on the first day, and maintained this high rate until depletion of excessive body stores of sodium.

In congestive heart failure patients, AQUATAG (benzthiazide) produced the same weight loss, during a 48-hour treatment period as did a maximally effective dose of hydrochlorothiazide.

DOSAGE: Diuresis, initially 50 to 200 mg.; maintenance 25 to 150 mg., daily. Hypertension 50 to 100 mg. initially, adjusted to 50 mg. t.i.d. or downward to minimal effective dosage level.

WARNINGS: Use with caution in the presence of renal disease as azotemia may be precipitated or increased. In patients with advanced hepatic disease, electrolyte imbalance may result in hepatic coma. Dosage of coadministered antihypertensive agents should be reduced by at least 50%. In cases of suspected electrolyte imbalance, serum electrolyte determinations should be performed and imbalance, if any, corrected. Stenosis or ulcer of small intestine have been reported with coated potassium formulas, and surgery has been required and deaths have occurred. Based on surveys of both United States and foreign physicians, incidence of these lesions is low and a causal relationship in man has not been definitely established. Until further experience has been obtained, the use of the drug in pregnant patients should be weighed against possible hazards to the fetus.

CONTRAINDICATIONS: AQUATAG (benzthiazide) is contraindicated in progressive renal disease or dysfunction including increasing oliguria and azotemia. Continued administration of this drug is contraindicated in patients who show no response to its diuretic or antihypertensive properties. Severe hepatic disease is a relative contraindication. (See "Warnings" above.)

PRECAUTIONS AND SIDE EFFECTS: Electrolyte imbalance with hypokalemia (digitalis toxicity may be precipitated), hypochloremic alkalosis and hyponatremia may occur.

Patients with cirrhosis should be observed for impending hepatic coma and hypokalemia. Other reactions may include blood dyscrasias, hyperuricemia and gout, nausea, jaundice, anorexia, vomiting, diarrhea, dizziness, paresthesia, photosensitivity and headache. Hepatic fetor, tremor, confusion and drowsiness are signs of impending pre-coma and coma in patients with cirrhosis. Insulin requirements may be altered in diabetes. AQUATAG (benzthiazide) should be used with caution post-operatively as hypokalemia is not uncommon. Potassium supplementation may be advisable pre- and post-operatively. There have been occasional reports of thrombocytopenia, leukopenia, agranulocytosis, aplastic anemia and precipitation of acute pancreatitis or jaundice.

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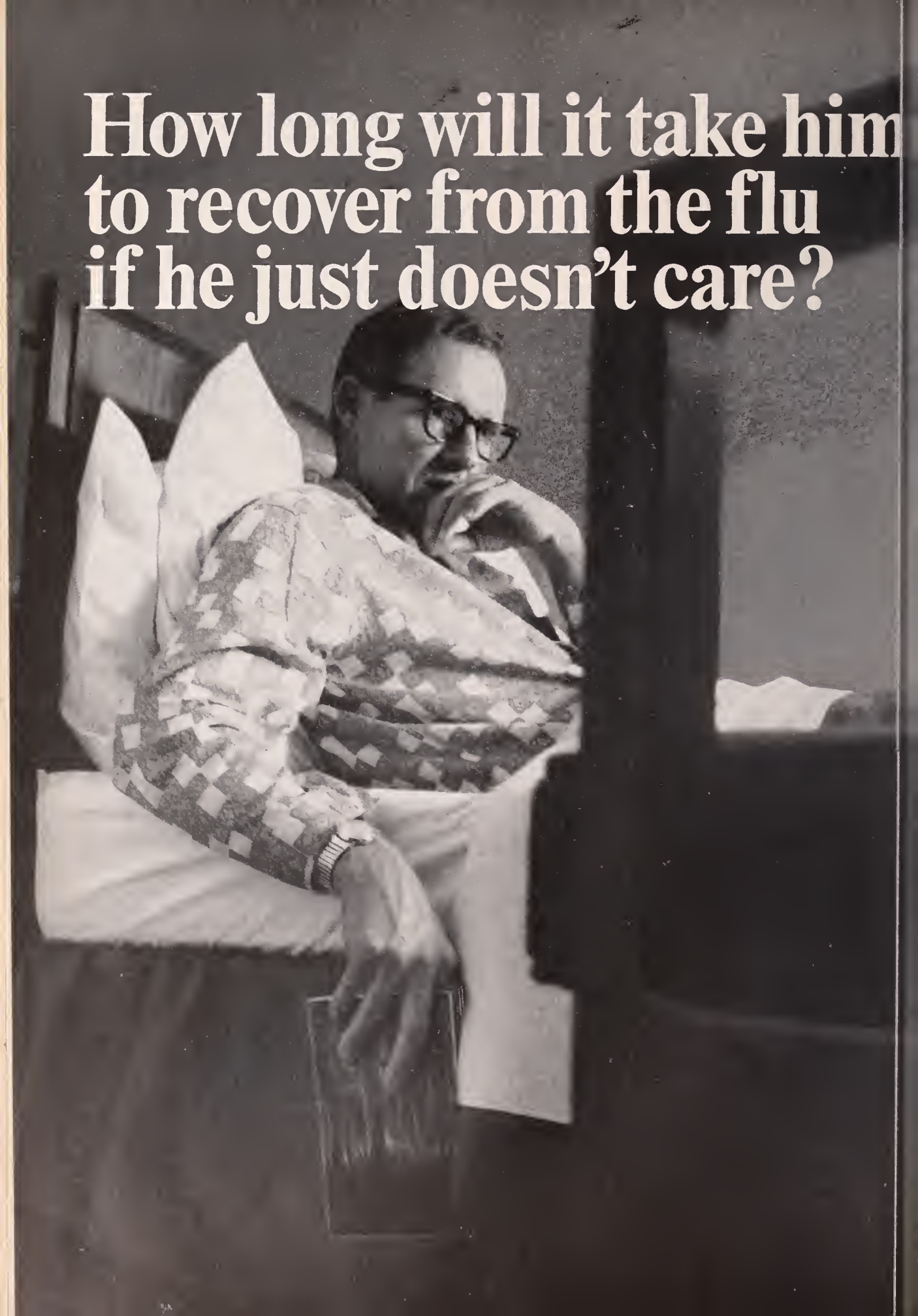
How long will it take him to recover from the flu if he just doesn't care?



Does he really care? Is he alert, encouraged, positive and optimistic about getting out of bed and back to work soon?

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Nothing fosters confidence and a sense of well-being better than your own personal warmth, understanding and encouragement together with Alertonic to help insure prompt response.

Adequate dosage is important: Prescribe Alertonic—one tablespoonful t.i.d., 30 minutes before meals...tastes best chilled.

And for your patient's sake, prescribe Alertonic in the convenient, economical one-pint bottle.

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Each 45 cc. (3 tablespoonfuls) contains: alcohol, 15%; pipradrol hydrochloride, 2 mg.; thiamine hydrochloride (vitamin B_1) (10 MDR*), 10 mg.; riboflavin (vitamin B_2) (4 MDR), 5 mg.; pyridoxine hydrochloride (vitamin B_6), 1 mg.; niacinamide (5 MDR), 50 mg.; choline,† 100 mg.; inositol,† 100 mg.; calcium glycerophosphate, 100 mg. (supplies 2% MDR for calcium and for phosphorus) and 1 mg. each of the following: cobalt (as chloride), manganese (as sulfate), magnesium (as acetate), zinc (as acetate), and molybdenum (as ammonium molybdate).

*Multiple of adult Minimum Daily Requirement supplied.
†The need for these substances in human nutrition has not been established.

Indications: 1. Functional fatigue such as that often associated with: a depressing life experience or stressful time of life; advancing years; convalescence; limited activity or confinement. 2. Poor appetite and vitamin-mineral deficiency as they occur in: patients having faulty eating habits; geriatric patients who are losing interest in food; patients convalescing from debilitating illness or surgery.

Contraindications: As with other drugs with CNS stimulating action, Alertonic is contraindicated in hyperactive, agitated or severely anxious patients and in chorea or obsessive compulsive states.

Side effects: Reports of overstimulation have been rare. Patients who are known to be unduly sensitive to the effects of stimulant drugs should be observed carefully in the initial stages of treatment.

Dosage: Adults, 1 tablespoonful; children (over 15 years old), 1 to 2 teaspoonfuls; children (4 to 15 years old), 1 teaspoonful. To be taken three times daily 30 minutes before meals.

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PHYSICIAN NEWS *continued*

Receives the Lederle Medical Faculty Award

Dr. Marc F. Hansen, assistant professor of pediatrics at the University of Wisconsin Medical School, recently received the Lederle Medical Faculty Award of 1966.

Dr. Weber Moves Into New Building

Dr. J. W. Weber recently moved to the new Weber Clinic in New London.

New Directors of Visiting Nurse Assoc.

Dr. Arthur Reinardy was named president of the directors of the Janesville area Visiting Nurse Association. *Dr. David Smith* was also named a director.

Dr. Gordon Participates in Obesity Seminar

Four of the world's leading medical authorities on obesity met at Dallas, Tex., recently in a seminar discussion of what a Swiss investigator has termed "an overlooked but immensely serious disease that is more common than the cold and perhaps a far greater contributor to man's unhappiness and loss of life than even cancer."

This statement, quoted by Dr. Jean Mayer, director of the Department of Nutrition at Harvard University's School of Public Health, opened the obesity seminar. The other participants in the seminar were Dr. Buron Cohen, senior attending cardiologist at St. Elizabeth's Hospital, New Jersey, and assistant professor of clinical medicine at New Jersey College of Medicine and Dentistry in Jersey City; *Dr. Edgar Stillwell Gordon*, professor of medicine and chief of the division of metabolism and endocrinology at University Hospitals, Madison Wis.; and Dr. Alvin Richard Feinstein, associate professor of medicine at Yale University.

Rotary Club Hears Dr. Boston

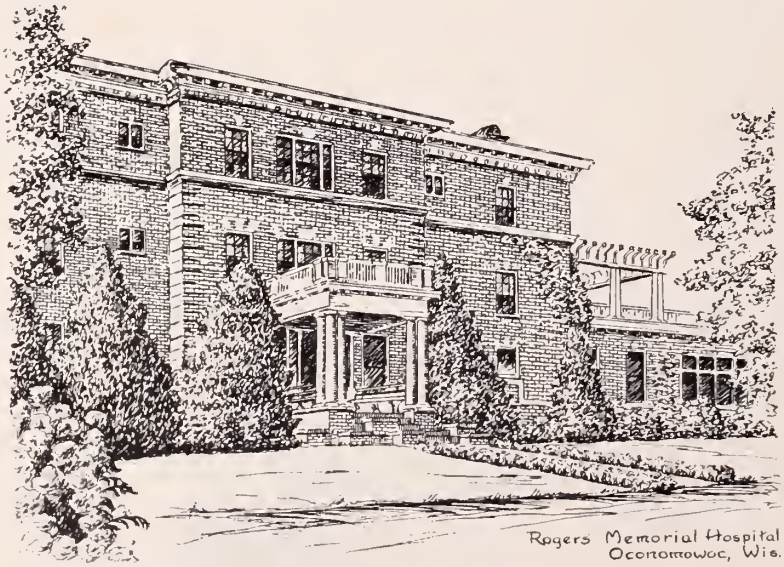
Dr. Tom Boston, Hillsboro, recently spoke before the Rotary Club in La Crosse on aviation. He is a practicing physician and president of the Vernon County Medical Society.

Dr. Rice Heads St. Joseph's Hospital Staff

Dr. Thomas Rice was recently reelected as chief-of-staff at St. Joseph's Hospital in Marshfield. *Dr. George River* was elected secretary, and *Dr. Robert Heywood* and *Dr. Donald Pederson* were elected to the executive committee of the staff.

Medical Staff Elects Officers

New officers were elected recently by the Sheboygan Memorial Hospital medical staff. Those chosen were *Dr. Paul P. Bassewitz*, president; *Dr. William Huibregtse*, vice-president; and *Dr. Henry Winsauer*, secretary–treasurer. In addition, *Dr. Earl Jochimsen* and *Dr. Robert Pointer* were elected to the executive committee.



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LOREN J. DRISCOLL, M. D.
THOMAS J. GORAL, M. D.
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One measure, of course, is reassurance. Another, adjunctive measure, is EQUANIL (meprobamate).

Over a decade of experience has shown that EQUANIL (meprobamate) is generally well tolerated as well as effective. Side effects are usually limited to transient drowsiness; serious, therapy-interrupting side effects are rare.

Cautions: Carefully supervise dose and amounts prescribed, especially for patients prone to overdose themselves. Excessive prolonged use may result in dependence or habituation in susceptible persons—as ex-addicts, alcoholics, severe psychoneurotics. After prolonged high dosage, drug should be withdrawn gradually to avoid possibly severe withdrawal reactions including epileptiform seizures. Side effects include drowsiness and, rarely, allergic or idiosyncratic reactions. These reactions, sometimes severe, can develop in patients receiving only 1 to 4 doses who have had no previous contact with meprobamate. Mild reactions are characterized by urticarial or erythematous maculopapular rash. Acute non-thrombocytopenic purpura with petechiae, ecchymoses, peripheral edema and fever have been reported. Meprobamate should be stopped and not reinstituted. Severe reactions, observed very rarely, include angioneurotic edema, bronchial spasms, fever, fainting spells, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case) and hyperthermia. Warn patients of possible reduced alcohol tolerance. Should drowsiness, ataxia, or visual disturbances occur, dose should be reduced. If symptoms persist, patients should not operate vehicles or dangerous machinery. A few cases of leukopenia, usually transient, have been reported following prolonged dosage. Other blood dyscrasias—aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis and hemolytic anemia—have occurred rarely, almost always in the presence of known toxic agents. One fatal case of bullous dermatitis following intermittent use of meprobamate with prednisolone has been reported. Prescribe very cautiously for patients with suicidal tendencies. Suicidal attempts should be treated with immediate gastric lavage and appropriate supportive therapy.

Contraindications: History of sensitivity to meprobamate.

Composition: Tablets, 200 mg. and 400 mg. meprobamate. Coated Tablets, WYSEALS® EQUANIL (meprobamate) 400 mg. Continuous-Release Capsules, EQUANIL L-A (meprobamate) 400 mg.

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Marquette Faculty Appointments

Two appointments have been made to the Marquette University School of Medicine's full-time faculty. Dr. Frederick M. Blodgett, a pediatrician, and *Dr. Donald J. Carek*, a child psychiatrist, will be located at Milwaukee Children's Hospital. Doctor Blodgett was an associate professor of pediatrics at Yale University Medical School before coming to Milwaukee. He holds memberships in the American Association for the Advancement of Science, the New England Pediatric Society, the Connecticut Pediatric Society, and the American Academy of Pediatrics. He received his specialty training at Massachusetts General Hospital, Boston.

F. M. Bladgett, MD

D. J. Carek, MD

Dr. Donald J. Carek comes to Marquette from the University of Michigan School of Medicine where he was assistant professor of psychiatry and director of day care at Children's Psychiatric Hospital, Ann Arbor. He is a graduate of the Marquette University School of Medicine and took his training in psychiatry and child psychiatry and child psychiatry at the University of Michigan. He is a member of the American ing script entitled "The Stroke Syndrome-Pathogene-

Kenosha Hospital Has New Officers

Dr. D. W. Davis recently assumed the duties of president and *Dr. Morris Siegel*, president-elect, of Kenosha Memorial Hospital. Also elected were *Dr. Stephen Holt*, secretary, and *Dr. Edwin H. Barnes*, representative to the board for a three-year term.

Dr. Ralph Hudson Speaks at Bloomer

Dr. Ralph Hudson, Eau Claire, recently addressed the Home and School Association of St. Paul's School in Bloomer. His subject was on sex education for the child.

Dr. Zupanc Speaks

Dr. Edward A. Zupanc, pediatrician at The Monroe Clinic, recently spoke at the New Glarus PTO meeting on child discipline.

Dr. Edwards Honored

Dr. A. C. Edwards, Racine city health commissioner, was recently honored at the annual meeting of the Visiting Nurse Association for his 21 years of service to the community. He was presented with a thermometer and humidity instrument. Keeping track of the weather is a hobby of his.

Dr. Mercer Named Head of Guidance Clinic

Dr. Wayne C. Mercer, psychiatrist, was recently named to head the staff at the North Central Guidance Clinic which has started operation in the Medical Arts Building in Ashland. Doctor Mercer graduated from the College of Medicine at the University of Iowa and took his advanced training in Boston, Mass., with the VA and had child psychiatric experience at Massachusetts General Hospital.

Dr. Ellison Picked by Surgical Group

Dr. Edwin H. Ellison, professor and chairman of the department of surgery at Marquette University School of Medicine and director of surgery at Milwaukee County General Hospital, was named president-elect of the Central Surgical Association

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Precautions: Keep out of reach of children. Carefully supervise dose and amounts prescribed, especially for patients prone to overdose themselves. Excessive prolonged use of meprobamate may result in dependence or habituation in susceptible persons—as ex-addicts, alcoholics, severe psychoneurotics. Withdraw gradually after prolonged high dosage to avoid possibly severe withdrawal reactions including epileptiform seizures. Warn patients of possible reduced alcohol tolerance. If drowsiness, ataxia or visual disturbances occur, reduce dose. If symptoms persist, caution patients against operating machinery or driving. Give cautiously to patients with suicidal tendencies. Treat attempted suicide with immediate gastric lavage and appropriate supportive therapy

Side Effects: Ethoheptazine and aspirin may occasionally cause nausea, vomiting, epigastric distress, and rarely dizziness and CNS depression. Overdosage may result in salicylate intoxication. Meprobamate rarely causes allergic or idiosyncratic reactions. These reactions, sometimes severe, can develop in patients receiving only 1 to 4 doses who have had no previous contact with meprobamate. Mild reactions are characterized by urticarial or erythematous maculopapular rash. Acute nonthrombocytopenic purpura with petechiae, ecchymoses, peripheral edema and fever have been reported. Meprobamate should be stopped and not reinstituted. Severe reactions, observed very rarely, include angioedema, bronchial spasms, fever, fainting spells, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case) and hyperthermia. A few cases of leukopenia, usually transient, have been reported following prolonged dosage. Rarely, cases of aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis, and hemolytic anemia have been reported; almost always, in the presence of known toxic agents.

Contraindications: History of sensitivity or severe intolerance to aspirin or meprobamate.

Composition: 150 mg. meprobamate, 75 mg. ethoheptazine citrate and 250 mg. aspirin per tablet.

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When pain evokes anxiety and tension, thereby heightening patient discomfort, a simple analgesic may only touch on part of the problem.

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Dosage: 2 tablets q.i.d. for three days; then if necessary 1 tablet q.i.d. until healing is complete. Bottles of 50 tablets.

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3 contusions
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5 postoperative
6 fractures
7 bruises
8 sprains

MADLAND

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PHYSICIAN NEWS *continued*

at its annual meeting in Milwaukee late in February. Doctor Ellison also has been president of the Society of University Surgeons. *Dr. Raymond R. Watson*, clinical associate professor of chest and heart surgery at Marquette, was elected to membership in the Central Surgical Association at the meeting.

Dr. Falk Addresses Lions Club

Dr. V. S. Falk, who recently returned from two months of volunteer service in Vietnam, addressed members of the Edgerton Lions Club February 23.

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COUNTY SOCIETY PROCEEDINGS

BROWN

The January 12 meeting of the Brown County Medical Society included a scientific lecture by *Dr. John Pellett*, associate professor of surgery at the University of Wisconsin Medical School, Madison, on "Pediatric Surgery." A discussion of the reorganization of state government as recommended by the Kellet Committee was conducted by *Dr. Lyle Edelblute* who urged members to let their legislators know their feelings in the matter.

During the business session, *Dr. George Nadeau*, Green Bay, spoke in regard to PACE, the Professional Association for Civic Education. *Dr. Jack Killins*, Green Bay, reported on his work in regard to the office of coroner in Brown County. From his contacts with the Protection Committee of the County Board and with the newly elected coroner, it appeared that a satisfactory arrangement could be developed for the present time. There had been no further action to the suggestion that Brown County initiate action to allow the use of the Medical Examiner system.

At the February 9 meeting, Dr. Philip White, chief of the department of neurology of Marquette University School of Medicine, Milwaukee, spoke on the subject "Clinical Application of Electroencephalography."

CHIPPEWA

The February 7 meeting of the Chippewa County Medical Society was held at the Hotel Northern, Chippewa Falls. Speaker was *Dr. Joseph M. Tobin* of Eau Claire. His topic was "Indications for Psycho-active Drugs."

DOUGLAS

A check for $3,242, the balance of the Sabin oral vaccine program fund conducted in 1963–1964 in Superior, was presented to the Superior State University Foundation on February 14. *Dr. Edward Stack*, Superior health commissioner, represented the Douglas County Medical Society at the presentation. The program was a joint venture of the Junior Chamber of Commerce and the Douglas County medical, nursing, and pharmaceutical organizations. The funds are earmarked for the Prof. Edward Bolander Scholarship Fund which is available to promising science students.

GREEN LAKE–WAUSHARA

In cooperation with the Green Lake–Waushara County Medical Society, the State Board of Health's mobile survey unit spent from February 20 to March 3 holding clinics for the detection of tuberculosis, other heart and lung abnormalities, and a check for diabetes.

Physicians whose names appear in italics are members of the State Medical Society.

LA CROSSE

Dr. E. A. Haunz, professor of medicine at the University of North Dakota, spoke to the La Crosse County Medical Society February 13 at the Fireside. His topic was "Current Concepts in the Management of Diabetes."

LINCOLN

The Lincoln County Medical Society is again cooperating with the Lincoln County Nursing Service in sponsoring the 1967 Immunization Clinics which began in January. Immunizations include diphtheria, tetanus, whooping cough boosters, and smallpox vaccination. Polio immunization is not being offered.

PRICE–TAYLOR

The Price–Taylor County Medical Society cooperated with the State Board of Health in offering a free screening test for a number of chronic diseases. The State's mobile casefinding unit spent 13 days in January and February holding clinics throughout Taylor county for the public and for the larger industries.

Dr. Ben Glover of the Department of Psychiatry, University of Wisconsin Medical School, Madison, was the guest speaker at the February 11 meeting of the Price–Taylor County Medical Society. His subject was on Depression. The program was conducted as an experiment via telephone hookup with the guest lecturer and Doctor Glover's commentary, followed by a question period.

During the business session, *Dr. Griffith L. Thomas* of Prentice was elected president because of a vacancy created by *Dr. Mahmood Mirhoseini* of Medford who has taken a one-year leave of absence to continue a residency program in surgery. *Dr. W. W. Meyer* of Medford is secretary–treasurer. *Dr. W. E. Niebauer* of Phillips, who is the society's vice-president, is in charge of the entertainment for the next quarterly meeting which will include the auxiliary.

WALWORTH

Fifty-seven members of the Walworth County Medical Society met January 19 in Fontana at The Abbey. Dr. Sam Stohl of the Family Medical Clinic, Rockford, Ill., spoke on the subject "Chiropractory, Fact or Fiction." During the business session, the Society discussed a request for a measles immunization free clinic by the Delavan Junior Women's Club.

REGIONAL WEATHER FORECAST

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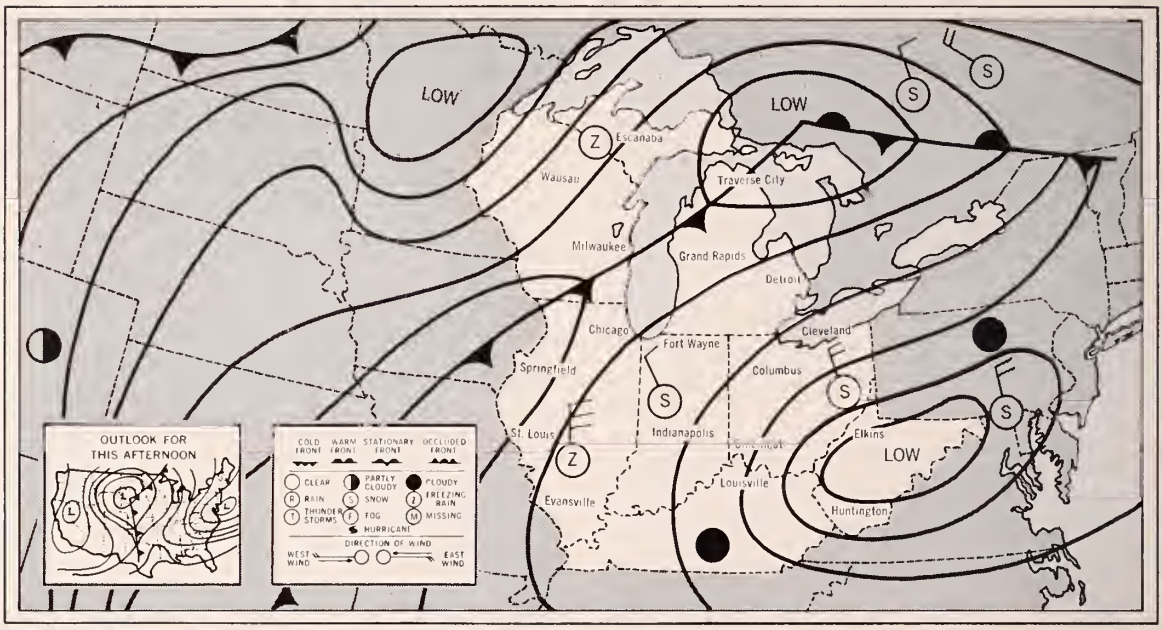

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SPECIALTY SOCIETY PROCEEDINGS

Milwaukee Academy of Medicine

The Arthur W. Rogers Memorial Lecture was given February 21 at the monthly meeting of the Milwaukee Academy of Medicine. Dr. Richard M. Paddison, professor and chairman of the Department of Neurology, Louisiana State University Medical Center spoke on "Neurology Comes of Age."

Wisconsin Psychiatric Association

Although there is general agreement that sexual attitudes and behavior in the American society are undergoing marked changes, there is little evidence that the rate of pre-marital sex relations among university students has increased radically, members of the Wisconsin Psychiatric Association were told during a three-day meeting at Oshkosh February 2–4.

This was the thinking of *Dr. Seymour L. Halleck*, associate professor of psychiatry at the University of Wisconsin–Milwaukee School of Medicine. He spoke on the subject "Sex and Mental Health on the College Campus." Doctor Halleck noted that there is "great support" for the theory that mental illness tends to be related to sexual promiscuity, adding that studies indicate a tendency toward promiscuity among disturbed delinquent girls, many of whom have despaired of achieving normal marital relationships.

Other speakers during the ninth annual meeting included Dr. David M. Reed, assistant professor of psychology at Tulane University, New Orleans, La.; Dr. Leslie H. Farber, a Washington, D. C. psychoanalyst, and Dr. Marjorie Bennett of Chicago.

During the business session on February 5, *Dr. Leigh M. Roberts* of Madison was elected president; *Dr. A. A. Lorenz* of Eau Claire, president-elect; *Dr. Herman P. Gladstone* of Madison, secretary; and *Dr. Raymond Headlee* of Milwaukee, treasurer. Officers of the WPA, a district branch of the American Psychiatric Association, take office in May following the annual meeting of the APA.

Drs. Jack J. Coheen, Milwaukee, and *Earl H. Jochimsen*, Sheboygan, were elected to the Council, the governing body of the association. The Wisconsin Psychiatric Association has a membership of 206 psychiatrists.

Physicians whose names appear in italics are members of the State Medical Society.

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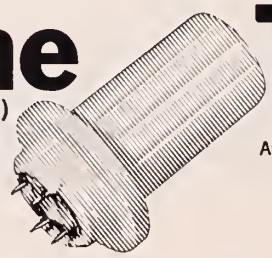

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Dane County Humane Society

Dr. William Waskow was elected president of the Dane County Humane Society at its annual meeting in January. Luther Albert, Ph.D., was named secretary. Both doctors were named as directors. In December, Doctor Albert was reappointed to the board of directors of the Wisconsin Society for Medical Research. Doctor Waskow is associated with the Department of Radiology, Jackson Clinic, Madison; and Doctor Albert is with the University of Wisconsin Animal Care Unit.

Wisconsin Division, American Cancer Society

The latest developments in cancer research and educational objectives in Wisconsin were reviewed at a luncheon marking the 20th anniversary of the Wisconsin Division of the American Cancer Society at Green Bay in January.

Dr. F. L. Schaefer of Neenah, chairman of the public education committee for the Wisconsin Division, reported on educational objectives. Dr. Henry C. Pitot, of Madison, a cancer researcher at the McArdle Memorial Laboratory, University of Wisconsin Medical Center, reported on his project, "Studying the Chemical Changes Which Take Place When Introducing Skin Cancer and Its Causes."

Wisconsin Medical Technologists Society

The winter meeting of the State Society of the American Medical Technologists was held in February at Calumet Memorial Hospital, Appleton. The educational program included three speakers: *Dr. James Jaeck*, pathologist of St. Nicholas Hospital, Sheboygan, who spoke on "Pitfalls in Hematology;" N. J. Bourdeau, microbiologist of the State Board of Health, who spoke on "Enteric Bacteriology Evaluation Program;" and Mrs. Jarel Kelsey, technical representative from Dane County, whose subject was "Quality Control."

International Society of Medical Directors of Chronic Disease Facilities

Preliminary steps were taken recently in Las Vegas, Nev., to form the International Society of Medical Directors of Chronic Disease Facilities. Dr. Bertram Moss of Chicago, Ill., was elected chairman of the new society and Dr. Thomas C. Kalkhof of Erie, Pa., was elected secretary. Mr. Samuel N. Turiel of Chicago, Ill., was named the executive director of ISMDCDF, with headquarters at 333 N. Michigan Ave., Chicago.

The new organization has been formed because of the Medicare ruling that every extended-care facility have a full-time medical director for all patients, both those covered by Medicare as well as those who are not. The new group will bring together physicians who will provide those services.

The first annual meeting of the society will be held in the Miami Beach area, December 1967. The primary membership classification will be Fellow, available to those physicians who serve as the medical director of a chronic disease facility such as nursing home, convalescent center, rehabilitation centers, and chronic disease hospitals.

Physicians whose names appear in italics are members of the State Medical Society.

PARAMEDICAL ANCILLARY GROUPS

Wisconsin Heart Association

The Wisconsin Heart Association has awarded five research fellowships to begin July 1, 1967, according to an announcement by *Dr. Ross Kory*, chairman of the association's research committee. The awards, totaling over $25,000, went to: Alberto S. Querimit, Ph.D., University of Wisconsin Medical School, who will work under the direction of *Dr. George Rowe*, professor of medicine at UW; Michael Keelan, Ph.D., Marquette University School of Medicine, and Howard W. Short, Ph.D., who will both work under the direction of *Dr. Ramon Lange*, head of the cardiovascular section at Marquette; Ronald Geller, UW, who will work under J. E. Kendrick, Ph.D., assistant professor of physiology; and Stephen Chen, Ph.D., UW, who will work under the direction of William B. Youmans, Ph.D., professor of physiology at UW.

American Heart Association

Two Wisconsin scientists have been awarded fellowships by the American Heart Association to support research toward the conquest of heart and blood vessel diseases, according to a recent announcement by *Dr. Hugh J. McLane*, president of the Wisconsin Heart Association.

Investigators named from the Wisconsin area were: Dr. Fritz H. Bach, University of Wisconsin Medical School, for study of immunological factors involved in tissue transportation and Paul D. Ray, Ph.D., University of Wisconsin, for study in gluconeogenesis—mode of action of adrenal glucose.

The Wisconsin fellowship awards are among 150 national awards totaling approximately $2,000,000 made to scientists under the national research support program of the AHA and its affiliates. The awards are for 12 months, beginning July 1, 1967.

Wisconsin Heart Association

During the month of February over 30,000 volunteers participated in the annual Heart Fund Drive sponsored by the Wisconsin Heart Association. Volunteers were expected to raise $771,000, the largest campaign goal in the history of the WHA.

Dr. Thomas C. Meyer, assistant dean and director of postgraduate medical education at the University

continued

of Wisconsin Medical School, is head of the 1967 Heart Fund Drive.

The Drive was launched in an unusual manner throughout the state on February 1 when Doctor Meyer addressed campaign leaders throughout Wisconsin simultaneously via a new telephone conference system capable of handling 73 outlets at the same time.

Doctor Meyer, speaking from Madison, discussed the "Latest Advances in Heart Surgery." Also speaking that evening was *Dr. Hugh J. McLane*, Fond du Lac, president of the WHA; Grant Larned, Milwaukee, executive director of WHA; and Kenneth Trierweiler, Milwaukee, director of field services for the WHA. Mr. Larned and Doctor McLane spoke from Fond du Lac while Mr. Trierweiler was in Madison with Doctor Meyer.

Attendance at the telephone event was around 125 campaign leaders and their guests. This was the first time a voluntary health agency has used this technique for a campaign kick-off anywhere in the United States, according to the WHA.

Doctor Meyer made a statewide tour in February addressing heart workers and civic groups, and visiting radio and TV stations and newspapers for interviews. The funds raised will be used to help over 250,000 cardiac patients in Wisconsin.

Wisconsin Inter-Agency Council on Smoking and Health

Formal organization of a Wisconsin Inter-Agency Council on Smoking and Health was completed at a meeting held January 19 at the State Board of Health office in Madison under the direction of State Health Officer *Dr. E. H. Jorris*. A constitution and bylaws were adopted and officers chosen for the council which will coordinate statewide efforts to point out the health hazards of cigarette smoking. Formation of the council followed a series of exploratory meetings at which *Dr. A. L. Van Duser*, director of the Division of Cancer Control of the State Board of Health, acted as chairman pro-tem.

Dr. Glenn A. Smiley of Delavan was elected chairman of the Council. Doctor Smiley is also chairman of the State Medical Society's Committee on Cancer, and is chairman of the Medical and Scientific Committee of the American Cancer Society, Wisconsin Division.

Leslie Johnson, superintendent of schools at Sheboygan and senior vice-president of the Wisconsin Congress of Parents and Teachers, was chosen vice-chairman of the Council. Elected secretary was Mrs. Richard Bakke, supervisor of the recruitment and stipend program of the State Department of Public Welfare. Robert Stutzman of the State Board of Health will serve as administrative staff secretary.

Groups represented at the organizational meetings include: Wisconsin Nurses Association; Wisconsin Association of Osteopathic Physicians and Surgeons; Wisconsin Anti-Tuberculosis Association; Wisconsin Heart Association; Wisconsin State Dental Society; Wisconsin Hospital Association; Wisconsin Congress of Parents and Teachers; American Cancer Society, Wisconsin Division; American Cancer Society, Milwaukee Division; State Medical Society of Wisconsin; University of Wisconsin Medical School; Marquette University School of Medicine; State Department of Public Welfare; State Board of Health; State Board of Vocational, Technical and Adult Education; State Department of Public Instruction.

Outagamie County Medical Assistants Society

The Outagamie County Medical Assistants Society participated in the Annual Workshop for high school students preparing for business careers held in Appleton on February 4. The workshop was sponsored by the Fox Cities Chapter of the National Secretaries Association (International). Mrs. Dorothy Smith, the county's representative, spoke on the steps she took to her present position and job experiences encountered as a medical assistant.

WISCONSIN ASSOCIATION OF PROFESSIONS

Do You Want to Become a Member?

The State Medical Society of Wisconsin is one of nine chartering organizations in the new WISCONSIN ASSOCIATION OF PROFESSIONS whose principal purpose as stated in the Articles of Incorporation is to promote ". . . the interests of the professions and their members in the State of Wisconsin."

The other eight groups are the professions of dentistry, veterinary medicine, law, architecture, education, pharmacy, public accounting, and professional engineering.

WAP will, with proper support, be an effective step toward greater public education concerning the contributions which professional men and women make to society. Further, it will be a stimulus to young people to seek out professional careers; a means of upholding the caliber of those drawn to the professions and of aiding them in their educational pursuits; and a UNIFYING FORCE TOWARD COMMON GOALS as professional people and active citizens of Wisconsin.

The strong element necessary to make WAP a vibrant and effective organization is individual membership support. Member organizations will benefit, too.

Annual dues for individual membership are $10.00. An application blank was sent recently to all members of the State Medical Society inviting them to become members of the Association. If further information is desired, contact Dr. H. J. Kief of Fond du Lac, Dr. Herman W. Wirka of Madison, or the State Medical Society.

OBITUARIES

Dr. Lewis A. Seymer, 81, who had practiced general medicine in Wauwatosa for more than 50 years and had been on the staff at St. Joseph's Hospital, Milwaukee, died Nov. 17, 1966. He had been ill for a year and had lived at the Harrison Nursing Home in Wauwatosa.

Born in Milwaukee, Doctor Seymer was graduated from the University of Illinois Medical School in 1913. He interned at Swedish Covenant Hospital, Chicago.

He was a member of The Medical Society of Milwaukee County, State Medical Society of Wisconsin, and American Medical Association.

Surviving are his widow, May, at the Harrison Nursing Home, and a daughter, Mrs. Karl Snyder, Fort Worth, Tex.

Dr. Robert O. Brunkhorst, 73, Milwaukee physician for more than 40 years and St. Joseph's Hospital staff member for 33 years, died Nov. 19, 1966, at his home in Shorewood.

Doctor Brunkhorst had offices in Milwaukee with his stepson, Dr. William T. Casper, from 1934 until his retirement in 1962. For 26 years he was a physician for the Wisconsin Athletic Commission.

A music enthusiast, Doctor Brunkhorst had been director of the Tripoli Shrine and Milwaukee police bands. In 1925 he organized the Tripoli Oriental band and led it until 1940. He was also director of the Professional Men's symphony orchestra for almost 20 years.

A native of Milwaukee, Doctor Brunkhorst was a 1919 graduate of Marquette University School of Medicine. He interned at St. Joseph's Hospital and served residency at Johnston Emergency Hospital, Milwaukee.

He was a member of The Medical Society of Milwaukee County, State Medical Society of Wisconsin, American Medical Association, and American Academy of General Practice.

In addition to his stepson, Doctor Casper of Bayside, Doctor Brunkhorst is survived by his widow, Carolyn, and another stepson, O. Charles Casper, Fort Lauderdale, Fla.

Dr. Paul C. Gatterdam, 68, who was on the staff of the Gundersen Clinic in La Crosse from 1926 until his retirement in June 1966, died Nov. 29, 1966, in La Crosse. He had practiced general and industrial medicine and surgery at the clinic and was a medical consultant to several La Crosse industries.

Doctor Gatterdam had also served on the La Crosse Board of Health for many years and as president for the past six years. He was a member of the La Crosse County Board of Health and was director of the state health clinic in La Crosse from 1928 to 1945.

From 1926 to 1941 Doctor Gatterdam was a major in the medical corps of the Wisconsin National Guard. During that period he was medical consultant for the Selective Service and physician for the La Crosse draft board. Since 1945 he had been a consultant to the draft board.

Born in La Crosse, Doctor Gatterdam completed his undergraduate studies at the University of Wisconsin and received his medical degree in 1924 from Washington University, St. Louis. He served internship and residency at La Crosse Lutheran Hospital.

He was a member and past president of the La Crosse County Medical Society, and a member of the State Medical Society of Wisconsin, American Medical Association, and Industrial Medical Surgeons.

Survivors are his widow, Ruth; two daughters, Mrs. Ted Kendall, Coloma, Mich., and Mrs. John Mess, Guatemala City, Guatemala; and a son, Paul, of Trenton, N. J.

Dr. George P. Dempsey, 78, who practiced general medicine in South Milwaukee for more than 40 years, died Dec. 6, 1966, in Milwaukee.

Born in Monches, Wis., Doctor Dempsey was a 1913 graduate of Marquette University School of Medicine, Milwaukee. He interned at St. Mary's Hospital, Minneapolis.

Doctor Dempsey was a member of The Medical Society of Milwaukee County, State Medical Society of Wisconsin, American Medical Association, and American Association of Railway Surgeons.

Survivors are his widow, Adeline, and a son, Dr. John M.

Dr. Andrew I. Rosenberger, 76, a Milwaukee psychiatrist from 1919 to 1965, died Dec. 13, 1966, in Santa Barbara, Calif.

While practicing in Milwaukee Doctor Rosenberger served as a consultant in neuropsychiatry at the Veterans Hospital, Wood, for several years.

A veteran of both World Wars, he retired from the army reserve in 1958 as a colonel. Born in Meadville, Pa., he was a graduate of Allegheny College, Meadville, and the University of Pittsburgh Medical School.

Doctor Rosenberger was a member of the American Medical Association, the State Medical Society of Wisconsin, and The Medical Society of Milwaukee County; and a fellow of the American College of Physicians and American Psychiatric Association.

Survivors are his widow, Gretchen; and three sons, Andrew J., Santa Barbara, Calif.; Thomas R., Fredonia; and John E., Mequon.

Dr. Eugene M. Juster, 70, vice-president and medical director of CUNA Mutual Insurance Society in Madison, died Dec. 15, 1966, at his home in Madison.

Doctor Juster had practiced general medicine with special attention to dermatology from 1926 to 1962 in Madison. He began full time work for CUNA in 1962, but he had worked there on a part time basis, as the first and only medical consultant for the Society, since it was organized in 1935.

A native of Milwaukee, Doctor Juster was a 1922 graduate of the University of Michigan Medical

School. He interned at Madison General Hospital, then practiced for a year in New Glarus.

He was a member of the Dane County Medical Society, State Medical Society of Wisconsin, American Medical Association, American Academy of Dermatology, and American Association of Life Insurance Medical Directors.

Surviving are his widow, Isabel; and three daughters, Mrs. Thorwald Esbensen, Duluth, Minn., Mrs. Craig Johnson, East Lansing, Mich., and Mrs. Henry Kaplan, Brookline, Mass.

Dr. M. V. Overman, 59, Neillsville general practitioner for 30 years, died Dec. 17, 1966, at his cottage near Moose Lake in the Hayward area. He was a former chief-of-staff at the Neillsville Memorial Hospital and was a director at the hospital at the time of his death.

Born at Balsam Lake, Doctor Overman was graduated from River State College and taught two years in Granton before entering medical school. He graduated in 1935 from the University of Wisconsin Medical School, Madison. He interned at St. Luke's Hospital, Duluth, Minn. He practiced for two years in Granton and five years in Greenwood before moving to Neillsville in 1942.

Doctor Overman was a member and past president of the Clark County Medical Society, a member of the State Medical Society of Wisconsin and its Commission on Hospital Relations and Medical Education, and a member of the American Medical Association and American Academy of General Practice.

Survivors are his widow, Evelyn; two sons, Thomas, of Tucson, Ariz., and Jerry, a student at the University of Minnesota; and a daughter, Mrs. Donald W. Johnson of Neillsville.

Excerpts from an article in the MILWAUKEE JOURNAL, Jan. 1, 1967

A FAREWELL TO DOC PIPPIN

Country Doctor, Fisherman, Hospital Founder, Flyer Was Beloved in His Town

By TOM GUYANT, of The Journal Staff

RICHLAND CENTER, Wis.—Doc Pippin died last week. All the town grieves. They loved B. I. Pippin here. He was a legend—not only the country doctor who made his rounds in a sputtering old car, but the town's first flier, its most traveled fisherman, the man who started the hospital, the adventurer who went down to the Florida Keys when they could be reached only by railroad, who liked what he found, bought land and stayed each winter.

. . . Doc was a bouncy man with a small sandy mustache and a face constantly dressed with laugh wrinkles. Nobody called him by his first name, Bueford. He was "B. I." or Doc.

When he wasn't delivering babies or bandaging scratches or quarantining happy kids with measles, he was fishing.

. . . Just last year he built some trout ponds to have fish handy.

Doc owned lots of planes in his time, 18 or 20, he would guess.

. . . A nameless Ontario lake was named Pippin lake because Doc visited it so often. When he was 66, Doc flew an air force jet. He was an active fisherman right up to the end.

. . . His home (in the Florida Keys) was constantly filled with guests from Wisconsin. His boat burned thousands of gallons of gas as Doc's friends fished.

I can see him now, sitting back, clasping his hands across his stomach, grinning and saying: "Let's play a hand of gin rummy and then do a little fishing."

Those who knew Doc Pippin are better men because of him.

Dr. Beauford I. Pippin, 74, a retired Richland Center physician, died Dec. 24, 1966, in Miami, Fla., after a long illness.

Born Nov. 21, 1892, near Excelsior in Crawford county, Doctor Pippin graduated from Marquette University School of Medicine in 1914 after which he completed a year's internship at St. Joseph's Hospital, St. Paul, Minn. He then entered the practice of medicine in his home community at Excelsior.

From 1917 to 1920 he served as a Captain in the U.S. Medical Corps during World War I. In 1920 he went to Chicago where he took specialized training in eye, ear, nose, and throat.

Doctor Pippin opened an office in Richland Center in 1924. The Richland Center Hospital opened that same year, and Doctor Pippin was an enthusiastic supporter and played an important role in its development.

He was active in numerous civic enterprises. His interests, aside from medicine, included fishing, golfing, hunting, racing, and farming. Upon his retirement in 1960, several civic clubs to which he belonged honored him with a testimonial dinner in recognition of his 46 years of practice in the area, and for his leadership and participation in the development of Richland Center.

Doctor Pippin was active in his medical society affiliations and served two terms on the Council of the State Medical Society, from 1937 to 1943.

Prior to his retirement and in the years that followed, Doctor Pippin and his wife spent the winters in Florida, but they returned to Richland Center for the summer months. He built a permanent home at Islamorada in the Florida Keys.

He was, until his retirement, a member of the Richland County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association.

He is survived by his widow, Mildred, a son, Dr. B. E. Pippin, Burlington; two daughters, Mrs. Peter Hensley, Stockton, Calif., and Mrs. Paul Magnusson, Minneapolis, Minn.

Dr. Frank O. Brunckhorst, 85, who started his medical career driving a horse and buggy in Hortonville, and spent 26 years as Neenah's city health officer, died Dec. 28, 1966, at the Grand Army Home at King where he and his wife had been members since Sept. 3, 1965.

Ten years ago he had been honored by the State Medical Society and elected to its Fifty Year Club.

Born in Kewaunee, Doctor Brunckhorst attended the University of Wisconsin and received his medical degree from the St. Louis University Medical School in 1906. After internship and further study in New York, he opened an office in Hortonville in 1910. Except for 22 months in the army in World War I, he practiced in Hortonville until moving to Neenah in 1929.

Doctor Brunckhorst became Neenah's city health officer in 1937 and held the post until his retirement in 1962. He was a member of the St. Elizabeth Hospital staff and an honorary member of the Theda Clark Hospital staff.

He was a life member of the Winnebago County Medical Society, State Medical Society of Wisconsin, and American Medical Association.

Surviving is his widow, Amelia.

Dr. Hilton L. Doeringsfeld, 60, a Platteville physician and surgeon for 34 years, died Dec. 29, 1966, in Elgin, Ill., where he had been visiting his daughter during the holidays.

Born in Fennimore, Doctor Doeringsfeld received a bachelor of science degree from Marquette University and his medical degree from Loyola University, Chicago. Following an internship at St. Elizabeth's Hospital, Chicago, he practiced in Milwaukee for a year before settling in Platteville in 1932.

He was city health officer at Platteville and health director at Platteville State University. He had been on the staff of the Platteville Municipal Hospital for many years, at various times serving as chief of staff. Before opening his own clinic in 1950, he had been associated with the former Cunningham Hospital Clinic.

During World War II he was an examiner for the Selective Service Board in the Platteville area. He was also instrumental in organizing the Red Cross Bloodmobile in Platteville.

Doctor Doeringsfeld was a member of the Grant County Medical Society, State Medical Society of Wisconsin, and the American Medical Association.

He is survived by his widow, Irene; a daughter, Mrs. Hugh Seeley, Elgin, Ill.; twin sons, Robert of Milwaukee and Richard, a dental student at Marquette University, Milwaukee; and one granddaughter, Susan Seeley, Elgin, Ill.

Dr. Raymond H. Ludden, 64, a retired Madison physician and surgeon, died Jan. 2, 1967, in a Madison hospital.

A native of Bloomington, he was a graduate of the University of Wisconsin Medical School in 1927. He took postgraduate work at the New York Lying-In Hospital and Cook County Hospital, Chicago. After practicing in Viroqua from 1928 until 1946, he maintained an office in Madison until his retirement in 1952 because of ill health.

Doctor Ludden served in the army from 1942 to 1946, taking part in the New Guinea and the Philippine campaigns, later landing with the occupational forces near Hiroshima. Discharged with the rank of major, he was the holder of the Bronze Star, five foreign service bars, and the Bronze Service Medal.

Doctor Ludden was a member of the Dane County Medical Society, State Medical Society of Wisconsin, American Medical Association, and the Wisconsin and American Academies of General Practice.

Survivors include his widow, Marion; and two daughters, Mrs. James L. Hatleburg, Washington, D. C., and Mrs. Mark J. Bates, Oakland, Calif.

Dr. Norman A. Franken, 56, a former Madison physician and surgeon, died in Havre, Mont., Jan. 4, 1967, after a long illness. He had practiced in Madison from 1942 to 1950. His body was returned to Madison for interment.

A native of Rockford, Ill., Doctor Franken received a B. A. degree from Marquette University and a medical degree in 1941 from the University of Wisconsin Medical School. While at Wisconsin he was the recipient of a three-year Bowman Cancer Foundation fellowship.

After World War II, he was the first flight surgeon for the Wisconsin Air National Guard and recently had served as a major with the Montana Air National Guard while practicing in Havre.

Doctor Franken was past president of the Montana division of the American Cancer Society and a director at the time of his death. He was a member of the American Medical Association, the Montana Medical Society, the Hill County Medical Society, and was also a fellow of the International College of Surgeons.

Prior to his move to Montana, he was a member of the Dane County Medical Society and the State Medical Society of Wisconsin.

He is survived by his widow, Jane; two sons, T/Sgt. Thomas, Montana Air National Guard, and Henry, Havre; and a daughter, Mrs. Robert Liberati. Willow Grove, Pa.

Dr. George J. Hathaway, 72, formerly of Superior, died Jan. 15, 1967 in Santa Fe, New Mexico where he was affiliated with the New Mexico state health department.

He was born in Chetek and graduated from the University of Cincinnati in 1921. He interned at Spears Memorial Hospital in Dayton, Ky. in 1922. Doctor Hathaway began practicing in Superior in

OBITUARIES *continued*

1924 and in 1940 he went with the medical detachment of the 128th Infantry, Wisconsin National Guard Unit and became surgeon for the 15th Corps of the Seventh Army. He was awarded the Croix de Guerre by the French Army and the bronze star by the U.S. Army. Upon return to the states, he was appointed as medical officer for the Superior subregional office of the Veterans Administration.

While practicing in Wisconsin from 1924 to 1955, Doctor Hathaway was a member of the Waupaca County Medical Society, State Medical Society of Wisconsin, and American Medical Association.

Surviving are his widow, Letitia; three sons, Doctor Robert of Waterloo, Iowa, Doctor Walter of Council Bluffs, Iowa, and Dr. David Hathaway, Rochester, Minnesota.

Dr. Philip H. Gutzler, 44, a former River Falls resident died Feb. 3, 1967, in Dallas, Tex. He was associated with the River Falls Clinic for 17 years before moving in December 1966 to Dallas where he was practicing at Oakcliff Hospital and Clinic at the time of his death.

Doctor Gutzler was graduated in 1948 from the Hahnemann Medical College in Philadelphia where he also interned in 1948–1949.

Doctor Gutzler was a member and past secretary–treasurer of the Pierce–St. Croix Medical Society, State Medical Society of Wisconsin and the American Medical Association. He also served as a delegate to the State Society for many years.

Surviving are two sons, Philip and John; three daughters, Mary, Ann, and Barbara and his mother, Mrs. Philip H. Gutzler, Sr. of River Falls.

SERVICES TO PHYSICIANS AND THE PUBLIC

from the

PUBLIC INFORMATION DEPARTMENT OF THE STATE MEDICAL SOCIETY

The following services are provided to member physicians and the general public, under the direction of the Commission on Public Relations and Communications—a standing committee of the Council. For the most part they are designed to assist the physician in preparing for participation in health education events such as speeches to non-medical audiences, or to provide factual health information directly to the general public. Address requests, or have your patients write: Public Information Department, State Medical Society of Wisconsin, Box 1109, Madison, Wis. 53701.

LOAN PACKETS

Packets of reference materials are provided, on a loan basis, on such topics as Fluoridation, Establishing a Practice, Health Fads and Fallacies, Alcoholism, Health Careers, Emotional Aspects of Malignancy, and numerous others.

FILM SERVICE

An index of films, suitable for both medical and non-medical audiences, is maintained by the Society. Please be as specific as possible concerning the desired topic. Since the Society does not maintain a film library and all films must be ordered from another source, two weeks notice is desirable. Cost normally involves only return postage, however in some cases there is a rental or service charge to be paid by the recipient.

HEALTH CAREERS MATERIALS

Materials on careers in medicine are available as references for physicians participating in Career Days and leaflets are available in quantity for distribution to groups. Reference materials on careers ancillary to medicine, and sources of loans and scholarships are also available.

HEALTH EDUCATION LITERATURE

Single pamphlets are available on a wide range of topics for individuals seeking factual information on health.

MOUTH-TO-MOUTH BREATHING AND CLOSED CHEST CARDIAC MASSAGE

Films and a demonstration manikin are available for special programs on mouth-to-mouth breathing and closed chest cardiac massage. The latter topic is considered appropriate for physicians, nurses, policemen, firemen and rescue personnel, and requires supervision of a physician trained in the technique.

SPEAKERS SERVICE

While it is normally desirable to have a local physician fulfill speaking engagements in his community, speakers are available on the state level where a special topic or audience size makes it desirable.

MEMBERSHIP REPORT AS OF FEBRUARY 15, 1967

NEW MEMBERS

Fraser, William E., 6215 Tenth Ave., Kenosha 53140.
Greblo, Zorislav, 301 Troy Dr., Madison 53704.
Pellicer, Joseph G., 1324 Schofield Ave., Schofield 54476.
Reyes, Jose E., Jr., 8011—14th Ave., Kenosha 53140.
Sipes, Donald R., 1551 Dousman St., Green Bay 54303.

CHANGES OF ADDRESS

Backs, Mark F., 20 S. Park St., Madison 53715.
Bares, George C., 638 Pleasant View St., Wauwatosa 53226.
Bogle, Warren C., 20 S. Park St., Madison 53715.
Christopher, Chris C., West Allis, to 950 N. 35th St., Milwaukee 53208.
Church, Ruth E., 116 Fountain Ave., Apt. 4, Waukesha 53186.
Corcoran, William A., Jr., 430 W. Jefferson, Port Washington 53074.
Cordes, V. J., Milwaukee, to 10625 West N. Ave., Wauwatosa 53226.
Craite, E. J., Milwaukee, to P.O. Box 184, Lake Tomahawk 54539.
Crennel, Ean H., 20 S. Park St., Madison 53715.
Damon, Richard A., P.O. Box 512, Beaver Dam 53916.
Dibble, James B., 715 S. Barstow St., Eau Claire 54701.
Drvaric, Emil, 3535 W. Oklahoma Ave., Milwaukee 53215.
Entwistle, Frederick R., Milwaukee, to 1000 Euclid Ave., Sioux Falls, S.D. 57105.
Farrell, H. J., Whitefish Bay, to 330 W. Silver Spring Dr., Milwaukee 53217.
Fliegel, M. B., 3418 Harper Rd., Madison 53704.
Gallagher, D. J., Beacon Medical Center, 505 S. Military Ave., Green Bay 54303.
Gettelman, Sydney T., Milwaukee, to 1850 Middleton Ave., Los Altos, Calif. 94022.
Grahek, Anthony S., 20 S. Park St., Madison 53715.
Handa, Yoshio, 20 S. Park St., Madison 53715.
Hellmuth, George A., Hartford to 750 N. 18th St., Milwaukee 53233.
Hoff, Allan Dale, 20 S. Park St., Madison 53715.
Hoffman, Philip A., 20 S. Park St., Madison 53715.
Hogan, Larry Howlett, 20 S. Park St., Madison 53715.
Hoggatt, John E., Racine, to 211 N. Commercial St., Neenah 54956.
Howard, Timothy J., 6760 N. Yates Rd., Milwaukee 53217.
Hudson, R. F., 715 S. Barstow St., Eau Claire 54701.
Keland, H. B., 5241 Short Rd., Racine 53402.
Kilpatrick, Leslie G., 20 S. Park St., Madison 53715.
Krembs, M. Alex, 811 E. Wisconsin Ave., Milwaukee 53202.
Landis, Ralph V., 210 N. Park Ave., Appleton 54911.
Lane, F. C., P.O. Box 374, Merrill 54452.
Lindner, Anton, Oklahoma City, Okla., to 121 De Kalb Ave., Brooklyn, New York 11201.
Longstreth, Charles R., 139 Wakaun Ave., Fond du Lac 54935.
Mackman, Sanford, 15 S. Yellowstow Dr., Madison 53705.
Marino, Rita, 811 E. Wisconsin Ave., Milwaukee 53202.
McAleavy, John C., 20 S. Park St., Madison 53715.
McClung, John L., 20 S. Park St., Madison 53715.
McDermott, James F., P. O. Box 7252, Wauwatosa 53213.
Mendeloff, Elton, Milwaukee, to 2320 W. Kenboern Dr., Glendale 53209.

SOCIETY RECORDS

Nemeth, Charles, 324 E. Wisconsin Ave., Milwaukee 53202.
Nicolaus, William H., 411 St. Mary's Blvd., Green Bay 54301.
Noll, David J., 20 S. Park St., Madison 53715.
Owen, John Dale, Milwaukee, to Sierra Vista Ranch, Box 7, Cave Creek, Ariz. 85331.
Pfefferkorn, Ethan B., Colby, to 11121 Lindblade St., Culver City, California 90230.
Pyka, Rudolf A., Marshfield, to 355 Ferracina Blvd., Redlands, Calif. 92373.
Rapkin, Mitchell A., 20 S. Park St., Madison 53715.
Rundle, Frank L., 20 S. Park St., Madison 53715.
Sablay, Nonito M., Elkhorn, to 7952 E. Brooks Dr., Temperance, Mich. 48182.
Waters, Darwin Diehl, 20 S. Park St., Madison 53715.
Westley, William, Jr., Milwaukee, to 5038 Spruce Ct., Greendale 53129.
Wilets, Jack C., 4300 W. Burleigh St., Milwaukee 53210.
Winston, Frank, 313 Price Pl., Madison 53705.
Wylde, Robert M., 20 S. Park St., Madison 53715.
Voet, Raymond K., Minneapolis, Minn., to U.S. Naval Radiological Defense Lab., Hunter's Pt., San Francisco, Calif. 94135.

REMOVED FROM MEMBERSHIP

Ansfield, David J., Milwaukee County, resigned.
Buzogany, William M., Dane County, resigned.
Case, Quentin C., Racine County, removed per county secretary.
Kohne, Ben D., Milwaukee County, resigned.

DEATHS

Randazzo, Salvatore, Nonmember, Dec. 1, 1966.
Rosenberger, Andrew, Milwaukee County, Dec. 12, 1966.
Brunckhorst, Frank O., Winnebago County, Dec. 28, 1966.
Doeringsfeld, Hilton L., Grant County, Dec. 29, 1966.
Hudek, Joseph, Nonmember, Dec. 31, 1966.
Ludden, Raymond H., Dane County, Jan. 2, 1967.
Franken, Norman, Nonmember, Jan. 4, 1967.
Hathaway, George J., Nonmember, Jan. 15, 1967.
Kelly, John P., Waukesha County, Jan. 25, 1967.
Ausman, Harry R., Milwaukee County, Jan. 26, 1967.

CORRECTION

Due to erroneous information received by the Membership Department, the address of John J. Sella, M.D., was changed from Milwaukee to Waterville, Me., in the December issue Society Records. Doctor Sella's current address is: 6114 West Capitol Drive, Milwaukee, Wis. 53216.

* * *

WIDOWS MAY NOW qualify for social security cash benefits as early as age 60.

BOOKSHELF

New books received are acknowledged in this section. From these books, selections will be made for reviews in the interest of the readers and as space permits. Reviews are written by members of the faculty of the University of Wisconsin Medical School. Books here listed will be available on loan from the Medical Library Service, S.M.I. Building, North Charter Street, Madison, Wisconsin 53706

BOOKS RECEIVED

MODERN HOME REMEDIES

And How to Use Them. By Morris Fishbein, M.D., editor of MEDICAL WORLD NEWS and WORLD WIDE ABSTRACTS OF GENERAL MEDICINE. Doubleday & Co. Inc., Garden City, N.Y. 1966. 129 pages. Price: $3.95.

MODERN TREATMENT

Vol. 3, No. 4. "Chemotherapy for Cancer," B. J. Kennedy, M.D., guest editor; and "Treatment of Respiratory Allergy," Samuel O. Freedman, M.D., guest editor. Hoeber Medical Division, Harper & Row, Publishers, New York. 1966. A bimonthly publication. Subscription: $16 per year.

THE NEW WAY TO LIVE WITH DIABETES

By Charles Weller, M.D., Larchmont, N.Y., director, Diabetes Research Unit, Grasslands Hospital; and Brian R. Boylan, medical journalist. Doubleday & Co., Inc., Garden City, N.Y. 1966. 133 pages. Price: $3.95.

PHYSICIAN'S LIABILITY

For Battery, Negligence, and Acts of Others; a programmed review for physicians. Developed by Educational Design, Inc. in collaboration with Pfizer Laboratories, SPECTRUM. Chas. Pfizer & Co., Inc. 1966. 47 pages.

QUESTIONS AND ANSWERS IN ORTHOPAEDICS

For Students, Interns, Residents, and Board Aspirants. By Floyd G. Goodman, M.D., and George R. Schoedinger, III, M.D., department of surgery, division of orthopaedic surgery, Washington University School of Medicine, St. Louis. C. V. Mosby Co., St. Louis. 1966. 244 pages. Price: $9.85.

STEREOSCOPIC ATLAS OF MASTOIDOTYMPANOPLASTIC SURGERY

By Harold F. Schuknecht, M.D., professor of otology and laryngology, Harvard Medical School; Werner D. Chasin, M.D., instructor in otolaryngology at Harvard; and John M. Kurkjian, M.D., assistant in otolaryngology at Harvard. C. V. Mosby Co., St. Louis. 1966. 92 pages. Price: $26.50.

SYNOPSIS OF NEUROLOGY

By Francis M. Forster, M.D., professor and chairman, department of neurology, University of Wisconsin Medical School, Madison. Second edition. C. V. Mosby Co., St. Louis. 1966. 218 pages. Price: $7.50.

BLOOD GLUCOSE LEVELS IN ADULTS

United States—1960–1962. Vital and Health Statistics, data from the National Health Survey. Series 11, No. 18 of the National Center for Health Statistics. U.S. Department of Health, Education, and Welfare, Public Health Service. September 1966. 25 pages. Price: 25¢

CONFLICT IN SOCIETY

Ciba Foundation Symposium. Edited by Anthony de Reuck and Julie Knight. Little, Brown & Co., Boston. 1966. 467 pages. Price: $13.

ETIOLOGY OF URINARY CALCULI

By L. B. Joshi, F.R.C.S., Joshi Hospital, Poona, India. 113 pages.

HEALTH IN HIGH SCHOOLS

Poona City (India) and District, 1963–1964. By L. B. Joshi, M.B.B.S., F.R.C.S., Joshi Hospital, Poona, India; and D. B. Sardesai, M. A., M.Sc., Gokhale School of Politics and Economics, Poona. 71 pages.

INTERVIEW RESPONSE ON HEALTH INSURANCE COMPARED WITH INSURANCE RECORDS

United States—1960. Vital and Health Statistics, Data Evaluation and Methods Research. Series 2, No. 18 of the National Center for Health Statistics. Department of Health, Education, and Welfare, Public Health Service. August 1966. 43 pages. Price: 35¢

IT ALL STARTED WITH HIPPOCRATES

A mercifully brief history of medicine. By Richard Armour. McGraw–Hill Book Co., New York, Toronto, London, Sydney. 1966. 136 pages. Price: $3.95.

MODERN TREATMENT

Vol. 3, No. 5. *Treatment of Gastrointestinal Infections*, guest editor, Marcel Patterson, M.D.; and *Treatment of Superinfections*, guest editor, Harold J. Simon, M.D., Ph.D. Hoeber Medical Division, Harper & Row, Publishers, Inc., New York. 1966. 1500 pages per year. Published bi-monthly. Subscription: $16 per year.

NURSING HOMES; HOMES FOR THE AGED

Licensed in Wisconsin, a directory. Wisconsin State Board of Health, Division of Hospital and Related Services, Madison. July 1, 1966. 72 pages.

PREVALENCE OF OSTEOARTHRITIS IN ADULTS

By age, sex, race, and geographic area; United States—1960–1962. Vital and Health Statistics, data from the National Health Survey. Series 11, No. 15 of the National Center for Health Statistics. U.S. Department of Health, Education, and Welfare, Public Health Service. June 1966. 27 pages. Price: 25¢

PRIMER ON PREMATURITY AND HIGH-RISK PREGNANCY

By S. Gorham Babson, M.D., associate professor of pediatrics, University of Oregon Medical School, and director of premature nursery, Doernbecher Memorial Hospital for Children, Portland, Ore.; and Ralph C. Benson, M.D., professor and chairman, department of obstetrics and gynecology, University of Oregon. C. V. Mosby Co., St. Louis. 1966. 194 pages. Price: $10.50.

REHABILITATION SERVICES IN HOSPITALS AND RELATED FACILITIES

A guide to planning, organization, and management. Published by the American Hospital Association, Chicago. July 1966. 66 pages. Price: $1.50.

RELATIONSHIPS: HOSPITALS AND HOSPITAL-BASED SPECIALISTS

Published by the American Hospital Association, Chicago. August 1966. 34 pages. Price: 75¢.

SURGICAL DISEASES OF THE CHEST

Edited by Brian Blades, M.D., Lewis Saltz professor of surgery and chairman of surgery, George Washington University School of Medicine, Washington, D.C. With 20 contributing authors. C. V. Mosby Co., St. Louis. 1966. 687 pages. Price: $25.

SYNOPSIS OF DERMATOLOGY

By William D. Stewart, M.D., clinical instructor in dermatology, University of British Columbia Faculty of Medicine, and associate in dermatology, Vancouver General Hospital, British Columbia; Julius L. Danto, M.D., visiting staff, St. Paul's and St. Vincent's hospitals, Vancouver; and Stuart Maddin, M.D., visiting staff, St. Paul's Hospital, Vancouver. C. V. Mosby Co., St. Louis. 1966. 664 pages. Price: $10.85.

WEIGHT BY HEIGHT AND AGE OF ADULTS

United States—1960–1962. Vital and Health Statistics, data from the National Health Survey. Series 11, No. 14 of the National Center for Health Statistics. U.S. Department of Health, Education, and Welfare, Public Health Service. May 1966. 38 pages. Price: 35¢.

DISEASES OF THE UVEAL TRACT

Vol. IX—System of Ophthalmology. Edited by Sir Stewart Duke-Elder, G.C.V.O., F.R.S., and Edward S. Perkins, Ph.D., M.D., F.R.C.S., Institute of Ophthalmology, University of London. C. V. Mosby Co., St. Louis. 1966. 978 pages. Price: $44.50.

FERTILITY TRENDS IN WISCONSIN, 1900–1964

By Zahava Fuchs and Douglas G. Marshall. No. 10, population series—Wisconsin's population. Department of Rural Sociology, College of Agriculture, University of Wisconsin, Madison. June 1966. 67 pages.

HANDBOOK OF OCULAR THERAPEUTICS AND PHARMACOLOGY

By Philip P. Ellis, M.D., associate professor and head, Division of Ophthalmology, Department of Surgery, University of Colorado Medical Center, Denver; and Donn L. Smith, Ph.D., M.D., professor, Department of Pharmacology, and dean, University of Louisville School of Medicine, Louisville, Ky. C. V. Mosby Co., St. Louis. Second edition. 1966. 224 pages. Price: $9.75.

OFFICE EVALUATION OF THE AGING PATIENT

Disease detection in persons over 45. Public Health Service publication No. 1513. U.S. Department of Health, Education, and Welfare, Division of Chronic Diseases, Gerontology Branch, Washington, D.C. August 1966. 20 pages. Price: 20¢.

THE CHANGING DISTRIBUTION AND ADEQUACY OF MEDICAL, DENTAL, AND HOSPITAL SERVICES IN RURAL AND URBAN COMMUNITIES IN WISCONSIN, 1910–1960

By Gordon L. Bultena. Department of Rural Sociology, College of Agriculture, University of Wisconsin, Madison. May 1966. 30 pages.

GRAY'S ANATOMY

Edited by Charles Mayo Goss, M.D., visiting professor of anatomy, George Washington University School of Medicine. Lea & Febiger, Philadelphia. 28th edition. 1966. 1,448 pages. Price: $22.50.

OBSTETRICS AND GYNECOLOGY

By J. Robert Willson, M.D., professor of obstetrics and gynecology, University of Michigan Medical School, and chairman of the department of obstetrics and gynecology, University of Michigan Medical Center, Ann Arbor; Clayton T. Beecham, M.D., director of gynecology and obstetrics, Geisenger Medical Center, Danville, Pa.; and Elsie Reid Carrington, M.D., research professor of obstetrics and gynecology, Woman's Medical College of Pennsylvania, Philadelphia. C. V. Mosby Co., St. Louis. Third edition. 1966. 776 pages. Price: $15.50.

WISCONSIN PUBLIC HEALTH STATISTICS 1965

Wisconsin State Board of Health, Division of Vital Statistics, Madison. 96 pages.

BOOK REVIEWS

APPRAISAL OF CURRENT CONCEPTS IN ANESTHESIOLOGY

Volume 2. Edited and assembled by John Adriani, M.D., Professor of Surgery, Tulane University School of Medicine, Clinical Professor of Surgery and Pharmacology, Louisiana State University School of Medicine, Director, Department of Anesthesiology, Charity Hospital of Louisiana, New Orleans, La. C. V. Mosby Co., St. Louis, Mo. 1964. 478 pages. Price: $10.75.

This volume is a collection of reviews prepared by members of Dr. John Adrian's department at Charity Hospital. It includes reviews of a wide variety of subjects relevant to anesthesiology. Each of the 45 topics presented includes a summary of background material as well as recent advances in the area discussed. The references are generally pertinent and include the more important papers on the subject being presented. The list of references is of value to one wishing to explore a given topic in greater depth. Since these reviews are prepared by a number of clinicians, the method and language of presentation vary considerably. On the whole they are good summaries—readable and fairly brief. This volume will be useful as a reference for those wishing brief summaries of current thinking on a variety of subjects.—BETTY J. BAMFORTH, M.D.

PATIENT CARE AND SPECIAL PROCEDURES IN X-RAY TECHNOLOGY 2nd Ed.

By Carol Hocking Vennes, R.N., B.S., and John C. Watson, R.T. Illustrated. C. V. Mosby Co., St. Louis. 1964. 228 pages. Price: $6.25.

The initial portion of the book, especially the chapters on "The Technician and the Patient," and "The Technician and General Patient Care," are excellent; and should be read by every student radiology technician.

On the other hand, the application of the book is definitely limited in regard to specific radiographic techniques. Only one way of doing each procedure is discussed and then frequently in too much detail. Most special or more complicated procedures can be done in several ways, and to be more effective, this

book should have discussed at least briefly the different methods of doing the procedures. The book is of no help to the student technician learning a procedure differently from the method described.

The portions dealing with instruction and explanation of each procedure to the patient is repetitive and could be presented in just one place in the book, not before each procedure.

This book appears to be the elementary or the initial book for the student x-ray technician, judging from the style in which it was written and the manner in which the material is presented. However, material also is presented which assumes prior knowledge of a certain subject. This is especially true in regard to radiographic physics.

In conclusion, the book is definitely limited in its discussion of the different radiographic procedures. It is excellent in its discussion of ethics in relationship to the x-ray technician, the relationship of the x-ray technician to other hospital personnel, and especially to the patient.—MARGARET C. WINSTON, M.D.

THE STORY OF BLOOD

By Kenneth Walker, M.A., M.B., B.Ch., F.R.C.S., F.I.C.S. Philosophical Library, New York, N. Y. 213 pages. Price: $6.00.

Especially in the spring of the year, laboratory physicians and hematologists encounter high school and college students who are writing book reports or research studies on blood and blood transfusions. Almost all of us have at various times wrung our hands and wished that there was some basic book they could be given which would get them started on the general field of blood. Here, at last, is such a book!

This book, written in a somewhat chatty informal style covers the subject of blood in general in a language which the average high school and college student could understand. A perusal of the table of contents shows: old ideas concerning blood, blood from the standpoint of a scientist, circulation, the heart, blood pressure, diseases of blood, blood transfusions, blood as a defense against disease, the role of blood plasma in the fight against disease (mainly simple immunology) and blood poisoning and other diseases. The sections on circulation, physiology of the heart, nervous control of the heart, and blood pressure are well written and easy to follow.

A possible fault of the book is that the main diseases of blood discussed are hemorrhage, anemia, and coagulation defects, while only one page is devoted to the subjects of polycythemia and leukemias. This may be remedied in a further edition, or if not, supplementary material is abundantly available in these fields. The chapter on blood transfusions is well done and is written simply. The author was at one of the shock stations in World War I where blood transfusions were initially tried, and his eyewitness account of transfusions, followed by his own personal experiences (carrying two glass jars full of red cells to the trenches for front line transfusions) make this an exceedingly interesting chapter historically.

The book is not written primarily for physicians or as a comprehensive literature search. On the other hand, it is well written for the average reader and it contains little tidbits of history, philosophy and physiology scattered throughout which are impossible to index, much less review. I feel that a copy of this book would be very useful to have in every high school and college library as well as every laboratory for a general reference.—BYRON A. MYHRE, M.D., Ph.D.

NEURO–OPHTHALMOLOGY

Symposium of the University of Miami and the Bascom Palmer Eye Institute Volume 2. Compiled and edited by J. Lawton Smith, M.D., Associate Professor of Ophthalmology, Associate Professor of Neurosurgery, and Assistant Professor of Neurology, University of Miami School of Medicine. C. V. Mosby Co., St. Louis. 1965. 278 pages. Price: $21.75.

This second, clinically-oriented neuro-ophthalmologic symposium held in January of 1965 at Miami is edited by Dr. J. Lawton Smith. In the first chapter Doctor Smith reviews syphilis in its relationship to the eye and recommends that everyone get (1) TPI and an FTA absorb test in any abnormal pupil, (2) traumatic dislocation of the lens, (3) uveitis, (4) retinitis pigmentosa-like fundi, and (5) optic atrophy when it is unexplained. He reiterates again that a simple VDRL test will miss at least half of the cases of latent ocular syphilis. He goes on to substantiate much of his work done in the monkey.

In chapter III Dr. David Cogan gives an excellent classification of heredodegenerations of the retina. Rather than classifying them on a clinical basis, he has critically analyzed them according to the pathologic lesions in the retina. This makes considerably more sense.

In chapter VI Doctor Walsh reviews his technique for doing visual fields and reviews some unusual visual fields in relationship to tumors of the optic nerve and orbital tumors in binasal hemianopsias as well as central scotomas.

In chapter VII Doctor Hollenhorst reviews his carotid occlusion and includes an excellent differentiation on the pupil. Doctor Hedges in chapter VIII reviews ocular ischemia including ischemic optic neuritis and temporal arteritis as a cause of sudden loss of vision. Dr. Richard Lindenberg reviews the neuro-pathology involving the geniculate and optic radiations, and finally, Doctors White and Leffler review the neurology of the orbicularis oculi and its clinical application.

This book is highly recommended for every ophthalmologist's office as it is a summary of the latest clinical application of neuro-ophthalmology and retinal disease.—RODNEY J. STURM, M.D.

The State Medical Society of Wisconsin

ORGANIZED 1841

F. E. DREW, Milwaukee, President
H. J. KIEF, Fond du Lac, President-Elect
R. E. CALLAN, Milwaukee, Speaker
G. A. BEHNKE, Kaukauna, Vice-Speaker
F. L. WESTON, Madison, Treasurer
MR. C. H. CROWNHART, Madison, Secretary

Councilors

J. C. FOX, La Crosse, Chairman
E. J. NORDBY, Madison, Vice-Chairman

Term Expires 1969

First District:
W. D. James.....Oconomowoc

Second District:
G. J. Schulz.....Union Grove

Term Expires 1968

Third District:
M. D. Davis.....Milton

Term Expires 1967

E. J. Nordby.....Madison
(Vice-chairman)

Term Expires 1969

C. W. Stoops.....Madison

Term Expires 1967

Fourth District:
H. W. Carey .....Lancaster

Term Expires 1967

Fifth District:
P. B. Blanchard.....Cedarburg

Sixth District:
James A. Sisk.....Fond du Lac

Term Expires 1968

John E. Dettmann.....Green Bay

Seventh District:
J. C. Fox.....La Crosse
(Chairman)

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Ninth District:
E. P. Ludwig .....Wausau

Tenth District:
W. R. Manz .....Eau Claire

Term Expires 1969

Eleventh District:
C. A. Grand.....Ashland

Twelfth District:
L. J. Van Hecke.....Milwaukee
W. J. Houghton.....Milwaukee

Term Expires 1967

W. J. Egan.....Milwaukee

Term Expires 1968

S. L. Chojnacki.....Milwaukee
S. W. Hollenbeck.....Milwaukee

Thirteenth District:
Marvin Wright.....Rhinelander

Term Expires 1967

J. H. Houghton.....Wisconsin Dells
(Past President)

Delegates to American Medical Association
(Terms end on December 31 of year indicated)

John M. Bell, Marinette, 1968
J. C. Fox, La Crosse, 1968
E. L. Bernhart, Milwaukee, 1968
R. E. Galasinski, Milwaukee, 1967
W. B. Hildebrand, Menasha, 1967
N. A. Hill, Madison, 1967

Alternates

C. J. Picard, Superior, 1968
George Collentine, Jr., Milwaukee, 1967

List of Officers and Scheduled Meetings of County Medical Societies

COUNTY	PRESIDENT	SECRETARY	MEETING DATE
Ashland–Bayfield–Iron	Harold Guzzo Washburn	C. A. Grand 206–6th Ave., W., Ashland	
Barron–Washburn–Sawyer–Burnett	John K. Hoyer Rice Lake	John Henningsen 24 W. Marshall, Rice Lake	Second Tuesday 7:30 p.m.
Brown	Francis B. Vande Loo Wrightstown	K. C. Mickle 3319 Delahaut Green Bay	Second Thursday*
Calumet	John A. Knauf Stockbridge	J. C. Pinney Hilbert	
Chippewa	Robert Mathwig Stanley	Frank B. Sazama 133 W. Central St. Chippewa Falls	Second Tuesday
Clark	J. W. Koch Colby	Bahri Gungor Neillsville	
Columbia–Marquette–Adams	Thomas S. Westcott 115 W. Chestnut Pardeeville	Frederick H. Bronson 310 W. Conant St. Portage	Every Third Month 7:00 p.m.
Crawford	James R. Wong 229 S. Michigan St. Prairie du Chien	H. L. Shapiro Prairie du Chien	Third Wednesday
Dane	C. K. Kincaid City–County Bldg. Room 507, Madison	E. L. Belknap, Jr. 20 S. Park St. Madison	Second Tuesday**
Dodge	Richard W. Way 209 S. Univ. Ave. Beaver Dam	Richard A. Damon P.O. Box 512, Beaver Dam	Last Thursday*
Door–Kewaunee	Nicholas R. Wagener 802 North 3rd Ave. Sturgeon Bay	Reynold M. Nesemann 213 Ellis St. Kewaunee	
Douglas	Victor E. Ekblad 1507 Tower Ave., Superior	Robert Sellers 2209 E. 5th St., Superior	First Wednesday* Hotel Superior
Eau Claire–Dunn–Pepin	William T. Mautz 204 E. Grand Ave. Eau Claire	Lou A. Raymond 605 Walker Ave. Eau Claire	Last Monday
Fond du Lac	Russell S. Pelton 416 Watson St. Ripon	John G. Parrish, Jr. 1921 Mulen Drive Fond du Lac	Fourth Thursday*
Forest	E. F. Castaldo Laona	D. V. Moffet, Crandon	
Grant	Paul K. Edwards Bloomington	H. W. Carey 257 Madison St., Lancaster	Last Thursday, March, June, Sept. and Nov.
Green	Leslie G. Kindschi 1770 13th St. Monroe	James H. Weeks 921 16th Ave., Monroe	
Green Lake–Waushara	Steve R. Osicka 147 N. State St., Berlin	Erich M. Schmidt P. O. Box 48, Berlin	Last Thursday, every other month starting in Jan.

* Except June, July and August. ** Except July and August.

List of Officers and Scheduled Meetings of County Medical Societies (Continued)

COUNTY	PRESIDENT	SECRETARY	MEETING DATE
Iowa	David R. Downs Dodgeville	H. P. Breier Montfort	Second Tuesday
Jefferson	Robert G. Handeyside 210 Madison Ave. Fort Atkinson	Stanley Vognar 210 Madison Ave., Ft. Atkinson	Third Thursday*
Juneau	J. H. Vedner Mauston	Jack Strong Mauston	Second Tuesday Hess Clinic in Mauston
Kenosha	Walter C. Rattan 6530 Sheridan Rd. Kenosha	Fredrick Wood, Jr. 6530 Sheridan Rd. Kenosha	First Thursday* Elks Club
La Crosse	Wm. B. Gallagher 312 State St. La Crosse	Gunnar A. Gundersen, Jr. 1836 South Ave. La Crosse	Third Monday
Lafayette	R. E. Hunter Argyle	L. L. Olson 504 Wells St., Darlington	Last Tuesday
Langlade	John E. Garritty Antigo	Donald V. Blink 837 Clermont, Antigo	First Monday
Lincoln	James F. Bigalow 712 E. 2nd St., Merrill	James S. Janowiak 716 E. 2nd St., Merrill	
Manitowoc	T. H. Rees 104 North 8th St. Manitowoc	M. A. Jacobi 2300 Western Ave. Manitowoc	Last Thursday
Marathon	Gregory J. Bachhuber 614—3rd Ave. Wausau	Gordon L. Backer 630 First St., Wausau	
Marinette–Florence	J. D. Zeratsky 1510 Main St., Marinette	K. G. Pinegar 516 Houston, Marinette	Third Wednesday St. Joseph's Hospital
Milwaukee	Christopher, R. Dix 2040 W. Wisconsin Ave. Milwaukee	William L. Coffey, Jr. 536 W. Wisconsin Ave. Milwaukee Mr. J. O. Kelley, Ex. Sec. 756 N. Milwaukee, Milw.	Second Thursday
Monroe	Dewitt Beehe Sparta	E. O. Lukasek 110 E. Franklin St.,, Sparta	Third Monday
Oconto	F. W. Klutzow Main St., Gillett	Kenneth L. Strebe 134 N. Main St., Oconto Falls	
Oneida–Vilas	I. Nik Nevin 134 N. Oneida Ave. Rhinelander	Marvin Wright 1020 Kabel Ave., Rhinelander	Monthly
Outagamie	James E. Gmeiner 1260 Valley Rd., Appleton	G. J. Petersen 506 E. Longview Dr. Appleton	Third Thursday* Elks Club
Ozaukee	George F. Savage 173 Prospect St. Port Washington	Philip W. Wallestad 502 W. Jefferson Port Washington	
Pierce–St. Croix	F. B. Klaas East Ellsworth	C. A. Olson Baldwin	Third Tuesday
Polk	Jack R. Inyart Osceola	D. F. Schwab Frederic	Third Thursday 7:00 p.m.
Portage	J. A. Litzow 405½ Main St. Stevens Point	J. F. Riordan 2501 Main St. Stevens Point	
Price–Taylor	G. L. Thomas P.O. Box 218, Prentice	Walther W. Meyer 410 S. Second, Medford	Last Saturday, Feb., May, Aug., and Nov.
Racine	William J. Madden 1841 Wisconsin Ave. Racine	Elizabeth A. Steffen 734 Lake St. Racine Mr. G. N. Geraghty 600 Villa Street, Racine Exec. Sec.	Third Thursday
Richland	Roy C. Glise 890 East Kinder St. Richland Center	L. M. Pippin 1313 W. Seminary St. Richland Center	First Thursday Richland Hospital
Rock	H. L. Burdick P.O. Box 8, Milton	William A. Pruett 2031 Riverside Dr., Beloit	Fourth Tuesday
Rusk	Joseph E. Murphy 403 East Miner Ave. Ladysmith	Wm. B. A. J. Bauer Ladysmith	First Tuesday
Sauk	Robert G. Hansel 407 Oak Street Baraboo	John T. Siebert 101 Fourth St. Baraboo	Second Tuesday*
Shawano	Donald W. Schulz 139 S. Main St., Shawano	A. J. Sebesta P.O. Box 311, Shawano	Third Wednesday
Sheboygan	Burnell F. Eckardt 1226 North Eighth St. Sheboygan	Robert A. Keller 718 South 27th St. Sheboygan	First Thursday
Trempealeau–Jackson–Buffalo	Charles F. Meyer Box 180 Independence	Eugene Krohn 221 Main St. Black River Falls	Fourth Tuesday
Vernon	Thomas Boston 840 Water Ave., Hillshoro	T. Zimmermann 100 W. Melby St., Westby	Last Wednesday
Walworth	E. D. Hudson Rt. 3, Hwy. 50 East Lake Geneva	R. D. Peterson Elkhorn	Second Thursday*
Washington	W. E. Scheunemann 626 Cedar St. West Bend	R. F. Sorensen 633 14th Ave., West Bend	Fourth Thursday
Waukesha	Richard G. Frantz 1111 Delafield St., Waukesha	D. P. Nachazel, Jr. 102 E. Main St., Waukesha	First Wednesday
Waupaca	Harry S. Caskey Clintonville	Joseph W. Weber 322 N. Water St. New London	
Winnehago	Frederick H. Smith 116 S. Commercial St., Neenah	Richard C. Wolfgram Route 4, Box 746, Oshkosh	First Thursday
Wood	J. L. Burns, Jr. 630 S. Central, Marshfield	J. J. Mulvaney 630 S. Central, Marshfield	Four times a year

* Except June, July and August.

the wisconsin medical journal

Official Publication of THE STATE MEDICAL SOCIETY OF WISCONSIN

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1967 WISCONSIN

May 9–11: State Medical Society annual meeting, Milwaukee.

May 20: Annual meeting, Wisconsin Heart Association, Milwaukee.

Aug. 24–26: Conference on "Current Concepts in Surgery" sponsored by the Department of Surgery, UW Medical Center, at Wisconsin Center, Madison.

Sept. 14: Symposium on stroke, sponsored by the Wisconsin Heart Association and the Adolf Gundersen Medical Foundation, La Crosse.

Oct. 16–20: Wisconsin Work Week of Health, State Medical Society of Wisconsin, Madison.

Nov. 17: Medical-Legal-Industrial Symposium on "Pulmonary Diseases in Industry," sponsored by Mount Sinai Hospital, at Pfister Hotel, Milwaukee.

1967 NEIGHBORING STATES

Apr. 27–29: Postgraduate course in obstetrics, University of Minnesota, Minneapolis.

May 1–3: 37th Tri-State Hospital Assembly, Chicago.

May 1–3: Postgraduate course in ophthalmology, University of Minnesota, Minneapolis.

May 10: "Head Injuries," eighth in a series of programs by the University of Chicago Hospitals and Clinics.

May 11–13: Fourth Midwest Anesthesiology Conference, sponsored by Illinois Society of Anesthesiologists, The Palmer House, Chicago, Ill.

May 25–27: Postgraduate course in surgery, University of Minnesota, Minneapolis.

June 1–3: Postgraduate course in anesthesiology, University of Minnesota, Minneapolis.

June 12–15: Catholic Hospital Association convention, Chicago.

June 19–21: Postgraduate course in "Clinical Applications—Recent Advances in Pharmacology," presented by the American College of Physicians, at the University of Iowa, Iowa City.

Aug. 14–18: Golden Anniversary Meeting of the American Dietetic Association, Conrad Hilton Hotel, Chicago.

Oct. 2–6: Annual clinical congress, American College of Surgeons, Chicago.

Oct. 4–5: Annual Midwest Interprofessional Seminar on Diseases Common to Animals and Man, University of Missouri, Columbia.

Oct. 11: Third Annual Kidney Disease Symposium, Sheraton-Chicago Hotel, Chicago.

1967 OTHERS

May 3: Scientific session, American Cancer Society, Dallas, Tex.

June 12–13: Postgraduate course on Obstetrics and Gynecology, University of Colorado School of Medicine, Denver.

June 18–22: 116th AMA annual convention, Atlantic City, N.J.

June 18–22: 44th annual convention of the Woman's Auxiliary to the AMA, Atlantic City, N.J.

June 25–July 2: Fifth International Congress of Chemotherapy, Vienna.

June 26–28: Spring Clinics, Children's Hospital, Denver.

July 2–6: European Cancer Meeting, Vienna.

July 14–15: Rocky Mountain Cancer Conference, Brown Palace–West Hotel, Denver, Colo.

1968 OTHERS

Oct. 21–25: Annual Clinical Congress, American College of Surgeons, Atlantic City, N.J.

For listing of other meetings see the JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION.

MEDICAL MEETINGS

POSTGRADUATE COURSES

Adolf Gundersen Visiting Professor

Col. John A. Moncrief, Department of the Army, U.S. Surgical Unit, Brooke Army Medical Center, Fort Sam Houston, Tex., will be the Adolf Gundersen Visiting Professor at the University Hospitals, Madison, May 3. His lecture on Burns will be presented at 4 o'clock. All physicians are welcome to attend. For further details, contact the UW Postgraduate Extension Division, Room 302, 333 N. Randall, Madison, Wis. 53706.

Wisconsin Pathologists Meeting Schedule

The State Medical Society's Section on Pathology will conduct a program on Tuesday, May 9, in conjunction with the 1967 Annual Meeting of the Society to be held in Milwaukee May 9–11.

A noon roundtable luncheon will be held at the Sheraton–Schroeder Hotel with Dr. Philip Piper of Madison, president of the Wisconsin Society of Pathologists, as moderator. Speaker will be Dr. Ludwik Gross, Chief of the Cancer Research Unit, Veterans Administration Hospital, Bronx, N. Y. His subject: *Viral Etiology of Leukemia and Lymphomas.*

The afternoon program will be held in Milwaukee Auditorium. Dr. Stanley Inhorn of Madison, Director of the State Laboratory of Hygiene, will be moderator. Theme of the program is: *The Role of Viruses in the Genesis of Neoplasia.* Speakers and their topics are as follows:

Dr. Ludwik Gross, *Oncogenic Viruses*, 2:00 pm; Dr. Carl Olson, Professor of Veterinary Science, University of Wisconsin, Madison, *Bovine Papilloma Virus*, 2:20 pm; Dr. Van Potter, University of Wisconsin Medical School, Madison, *Varieties of Molecular Defects in Chemical Carcinogenesis*, 2:40 pm.

At 3:00 pm there will be a recess to view exhibits followed by a panel discussion.

Spring Meeting, Wisconsin Pathologists

The mid-year Spring Meeting of the Wisconsin Society of Pathologists will be held Saturday, June 10, in Madison at a location yet to be selected.

There will be a morning presentation of scientific papers by members and residents. A noon recess will be followed by an afternoon Tissue Seminar. Moderator will be Dr. Robert J. Hartsock, Chief,

Hematologic Pathology Branch, Armed Forces Institute of Pathology.

Subject of the seminar is: *Lymphoproliferative Disorders.* (Seminar slide sets are available on a first-come, first-serve basis at $10 per set. Address inquiries to the Wisconsin Society of Pathologists, c/o David J. La Fond, M.D., Secretary, 561 North 15th Street, Milwaukee, Wis. 53233.)

There also will be a Board of Directors meeting and a dinner with a business session.

Course in Medical and Science Writing

Three days of seminars on the writing of medical and other scientific manuscripts will be held May 12–14 at Big Sur, Calif., under the joint sponsorship of the Esalen Institute and the Northern California Chapter of the American Medical Writers' Association.

The program will alternate between lectures and workshops. W. D. Snively, Jr., M.D., a former president of AMWA, will teach a course in Sentence and Paragraph Structure. In one of the workshop sessions, which will be under the direction of Paula Harris, president of the Northern California AMWA, and Harley Messinger, M.D., a past president, participants will be required to write an abstract of an assigned article, and the abstracts will then be criticized.

Another workshop will deal with Intensive Editorial Review of a Manuscript, and a third will take up Approaches to the Subject.

Membership in the sponsoring organizations is not necessary for enrollment. The $60 fee for the course includes room and meals. For registration or further information, contact: Harley Messinger, M.D., Ph.D., 3029 Benvenue Avenue, Berkeley, California 94705. Telephone 841–8693 or 843–2576.

MAY 15 DEADLINE FOR SUBMITTING ABSTRACTS FOR AHA'S ANNUAL SCIENTIFIC SESSIONS

May 15, 1967, is the deadline for submitting abstracts of papers to be considered for presentation at the American Heart Association's 1967 Scientific Sessions. The sessions will be held October 20–22 in San Francisco's Convention Hall.

Papers should be based on original investigations in the cardiovascular or related fields. Abstracts, briefly digesting results obtained and conclusions reached, are limited to 250 words.

Forms for submitting abstracts and applications for scientific exhibit space may be obtained from the Department of Medical Education, American Heart Association, 44 E. 23rd St., New York, N.Y. 10010. Space for industrial exhibits may be requested through Steven K. Herlitz, Inc., 850 Third Ave., New York, N.Y. 10022.

OB–GYN Postgraduate Program, Denver

The Department of Ob-Gyn and the Office of Postgraduate Medical Education of the University of Colorado School of Medicine will conduct an Obstetrics and Gynecology course June 12 and 13 at the Denison Auditorium, Humphrey's Postgraduate Center, in Denver.

Guest faculty include: Curtis J. Lund, MD, professor and chairman, Department of OB-GYN, University of Rochester School of Medicine, Rochester, N.Y.; and Robert A. Munsick, MD, professor and chairman, Department of OB-GYN, University of New Mexico School of Medicine, Albuquerque, N. Mex.

Further details from, Office of PME, U of C School of Medicine, 4200 East Ninth Ave., Denver, Colo. 80220.

Rocky Mountain Cancer Conference

Denver, Colorado, the Mile High City, is once again the site of the Rocky Mountain Cancer Conference, July 14–15, at the Brown Palace–West Hotel. The 21st Annual Rocky Mountain Cancer Conference will feature some of the nation's most distinguished speakers on the subject of cancer during the two days it will be in session.

Morning symposia will deal with "What's New in Cancer" and "Cancer of the Biliary System and Its Related Structures." The afternoon session of the first day will be devoted to scientific papers by guest speakers with the second afternoon devoted to an "Information Please" session.

Dr. Milford O. Rouse, now president-elect of the American Medical Association, and Dr. Ashbel C. Williams, president of the American Cancer Society, will participate in the Conference which is held annually in Denver, Colo., and co-sponsored by the Colorado Division of the American Cancer Society and the Colorado Medical Society.

Speakers on the two-day scientific program include: Arthur J. Hunnicutt, M.D., a Surgeon from Oakland, California; William T. Moss, M.D., Director, Therapeutic Therapy, Chicago Wesley Memorial Hospital; Richard J. Reitemeier, M.D., Chairman of the Section on Internal Medicine, Mayo Clinic, Rochester; William O. Russell, M.D., Chief of Pathology, M.D., Anderson Hospital, Houston; and Wendell M. Stanley, Ph.D., Nobel Prize Winning Virologist, University of California, Berkeley.

Further information may be obtained by writing ROCKY MOUNTAIN CANCER CONFERENCE, 1809 East 18th Avenue, Denver, Colo. 80218.

Symposia on Iron Storage, Colitis, Among Scientific Programs at AMA Annual Convention

Symposia of treatment to both the generalist and the specialist will be included in this year's Scientific Program of the American Medical Association's Annual Convention.

The Convention will be held in Atlantic City, June

22, the Scientific Program in Convention Hall and surrounding hotels and the House of Delegates at the Chalfonte–Haddon Hall Hotel.

A Symposium on Absorption and Storage of Iron will be presented as a joint meeting of the Sections on Pathology and Physiology, Internal Medicine, Experimental Medicine and Therapeutics, and Gastroenterology.

The Sections on Radiology, Proctology, Pediatrics, General Surgery, Internal Medicine, and Gastroenterology will join for a Symposium on Granulomatous Colitis and Ulcerative Colitis in Children.

Other symposia are being planned and scheduled.

The entire Scientific Program for the 1967 Annual Convention will be published in the May 8 issue of the *Journal of the American Medical Association.*

STATE MEDICAL SOCIETY OF WISCONSIN

1967 ANNUAL MEETING

Tuesday–Thursday, May 9–11, Milwaukee

"Controversies in Medicine"

SCIENTIFIC PROGRAM HIGHLIGHTS

TUESDAY, MAY 9

9:30 Scientific programs, Milwaukee Auditorium: "Shock" and "Thyroid Disease"

12:30 Scientific luncheons, Sheraton–Schroeder Hotel: Internal Medicine, Obstetrics and Gynecology, Pathology, Radiology, and Surgery

2:00 Scientific programs, Milwaukee Auditorium: Internal Medicine, General Surgery, Pathology, and Radiology

WEDNESDAY, MAY 10

9:30 Scientific programs, Milwaukee Auditorium: "Hormones in Women" and "Radioisotopes in Diagnosis"

10:00 Resident–Intern program, Milwaukee Auditorium

12:30 Scientific luncheons, Sheraton–Schroeder Hotel: Internal Medicine, Obstetrics and Gynecology, Pediatrics (and Internal Medicine), Psychiatry, Radiology, and Surgery

2:00 Scientific programs, Milwaukee Auditorium: "Cardiovascular Disease," Obstetrics and Gynecology, Pediatrics, and Psychiatry

THURSDAY, MAY 11

9:30 Scientific programs, Milwaukee Auditorium: "Kidney Transplants" and "Care of the Dying"

9:30 Ophthalmology demonstrations and exhibit, Sheraton–Schroeder Hotel

10:00 Otolaryngology scientific program, Milwaukee Auditorium

12:30 Scientific luncheons, Sheraton–Schroeder Hotel: Anesthesiology, Dermatology, Internal Medicine, Ophthalmology, Orthopedic Surgery, and Otolaryngology

2:00 Scientific programs, Milwaukee Auditorium: Anesthesiology, Dermatology, Orthopedic Surgery, and Surgery

2:00 Ophthalmology scientific program, Sheraton–Schroeder Hotel

4:00 Otolaryngology lecture, University Club

continued on page 12

COMPLETE PROGRAM APPEARED IN THE MARCH ISSUE

Medical Students Hold 13-School Regional Meeting

Medical students from 13 midwest schools met at the State Medical Society headquarters and the Park Motor Inn in Madison March 4–5 for a regional convention of the Student American Medical Association (SAMA).

In addition to the two Wisconsin medical schools, Marquette University and the University of Wisconsin, others represented were the state universities of Minnesota, Iowa, Nebraska, North Dakota, South Dakota, Illinois; Northwestern, Chicago, Creighton and Loyola (Chicago) universities; and Chicago Medical School.

Nearly 100 delegates attended. The Woman's Auxiliary to SAMA held its regional meeting in conjunction with that of the medical students.

Drs. C. G. Reznichek and *C. W. Stoops* of Madison assisted the Wisconsin chapter in hosting the group.

MEDICAL STUDENTS AT ONE OF THE workshop sessions held at Society headquarters during the two-day regional meeting of the Student American Medical Association March 4–5.

THE WOMAN'S AUXILIARY to the SAMA met concurrently during the SAMA regional meeting in Madison.

Drama in UW "In-Depth" Surgical Program

The program on "Fractures and Other (Highway) Trauma" presented by the Department of Surgery, University of Wisconsin Medical School, February 8, at State Medical Society headquarters, was dramatized by a simulated traffic "emergency." Medical students were the "victims," and the demonstration emphasized the importance of emergency care on the scene of the accident. *Dr. Herman W. Wirka* headed a panel discussing various aspects of emergency care. Others on the panel were *Drs. Kenneth E. Lemmer*, Theodore Feierabend, *John B. Wear, Jr.*, *Joseph W. Gale*, Robert Baker, and *M. J. Javid.*

Over 60 physicians attended the program which was the fourth in a series of five one-day "in-depth" teaching sessions provided by the University of Wisconsin Medical School in cooperation with the State Medical Society and the Madison Chapter of the Wisconsin Academy of General Practice.

SOCIETY HEADQUARTERS *continued*

The morning session was held at University Hospitals. Doctor Wirka was moderator of the program. Speakers were *Drs. Sion Rogers, James Huffer, Henry Okagaki* of the UW, and Dr. Robert Baker, guest lecturer who is associate director of the Division of Surgery, Cook County Hospital, Chicago, Ill.

Following lunch at the SMS building, Professor Arch Easton of the Civil and Mechanical Engineering Department, University of Wisconsin, began the program with a discussion of Mechanical Problems in Automotive Safety. Comments were then made by *Dr. James L. Weygandt*, Sheboygan Falls, chairman of the Society's Division on Safe Transportation of the Commission on State Departments. The panel and dramatization of an accident followed.

MEETINGS AND SPECIAL EVENTS HELD AT THE STATE MEDICAL SOCIETY "HOME" DURING THE MONTH OF MARCH 1967

1 Planning Committee, Wisconsin Regional Medical Program
1 Trustees, SMS Realty Corporation
2 State Board of Health (Madison)
3 Senior Medical Students, University of Wisconsin Medical School
4 Region 5, Student American Medical Association and Auxiliary
5 Region 5, Student American Medical Association and Auxiliary
7 Board of Trustees, Dane County Medical Society
7 Surgical Staff, Madison General Hospital
7 Madison Urological Society
7 Madison Anesthesiology Society
9 UW "In Depth" Scientific Program
9 Wisconsin Alumni Research Foundation
9 Subcommittee, Maternal Mortality Study Committee
10 Executive Board, Woman's Auxiliary to SMS
10 Executive Committees, Council and Wisconsin Hospital Association
11 Executive Committee, Council
11 Finance Committee, Woman's Auxiliary to SMS
11 Executive Board, Wisconsin Academy of General Practice
11 Council
11 Scientific Medicine Committee, Council
12 Council (Realty Corporation)
13 Woman's Auxiliary to Dane County Medical Society
13 Madison District, Association of Licensed Practical Nurses
15 Executive Committee, Section on Ophthalmology
16 Board of Directors, Wisconsin Association of Professions
18 Wisconsin Regional Medical Program (UW and Marquette)
23 Madison Radiology Study Group

Meetings not held in the Society "Home" but have a direct relationship are printed in italics, with the location in parentheses.

MEDICAL STUDENTS, acting as highway traffic victims, provided visual demonstration for lecturers at the February 8 "in-depth" program. Dr. Herman W. Wirka is shown above as he examines one of the "victims." Seated in the background are Dr. Theodore Feierabend and Dr. Joseph W. Gale, all members of the University of Wisconsin Medical School faculty.

Over 225 Attend Final "In-Depth" Scientific Teaching Session of UW

The Fifth and final "in-depth" teaching program for the 1966–1967 season was held March 9 at State Medical Society headquarters, Madison General and St. Mary's hospitals. The one-day session, sponsored by the University of Wisconsin Medical School in cooperation with the State Medical Society, covered the subject of Cardiac Emergencies and Intensive Coronary Care.

DOCTOR WILLIAM ROCK of Madison explains the operation of a new cardiac monitor and pacemaker facility installed recently in the new wing of St. Mary's Hospital in Madison. The demonstration was part of a postgraduate program on "cardiac emergencies and intensive care" sponsored by the University of Wisconsin and the State Medical Society of Wisconsin.

PHYSICIANS FROM AS FAR AS Shawono and Eau Claire attended the final postgraduate program of an "In Depth" series sponsored by the UW and SMS. They ore shown here during the afternoon session in the Presidents Room of the State Medical Society headquarters.

Attendance reached over 225 with about an equal number of physicians and hospital personnel, namely nurses and technicians. During the morning, physicians visited the two Madison hospitals where they studied the clinical aspects of the subject. The afternoon program, held in the Presidents Room of State Medical Society headquarters, consisted of lectures and discussion.

UW faculty participants included *Drs. Paul Vastola, William Rock, Walter R. Sundstrom, John J. Brandabur, A. J. Riehtsmeier*, and *Paul O. Simenstad.*

LET THESE GUIDES HELP YOU

The following guides and manuals have been prepared at the direction of a number of councils, commissions, divisions, and committees of the State Medical Society to be of direct personal assistance to the physician or his county society. Each is available without cost upon request to the State Medical Society office, Box 1109, Madison, Wisconsin 53701.

Interprofessional Code

An instrument for better understanding between attorneys and physicians with reference to medical testimony and interprofessional conduct and practices.

Guide to The Service Corporation Law

A series of questions and answers describing Chapter 350, Laws of Wisconsin, 1961, allowing physicians, among others, to form private medical corporations for the tax benefit of their stockholders.

Code of Necropsy Procedure

A guide to physicians, hospitals, and funeral directors in the performance of necropsies.

Hearing Conservation Programs for Wisconsin Industries

Some recommended standards and principles for providing a hearing conservation program in industry.

Occupational Health, A Guide for Medical and Nursing Personnel

General principles and suggested plans for an industrial health program, with emphasis on written procedure for nurses.

New expanded edition—$5.00 with binding, $4.00 without binding. Ideal for any industrial plant with nurse service.

Find Your Future in the Health Field

A career guide (the health careers brochure).

Guide to Immunization Planning

An approved guide including recommended procedures for routine immunizations, parental responsibility, physician responsibility, medical society responsibility and steps for successful community planning.

Inspection of Medical Records

An interpretation of Chapter 301, Laws of 1959 relating to the right of access to physician and hospital records concerning patient care. Sample consent forms are included.

Principles for Transporting the Ill and Injured

A guide for providing emergency transportation services, including model community and state ordinances.

School Vision Screening Program

An outline to facilitate the development of a program to detect significant visual defects among school children.

First Aid Chart

Guide to Interpretation of Chapter 484, Laws of Wisconsin, 1959

Relating to fee splitting between physicians and others.

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pyelonephritis?
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Precautions: As with all new drugs, blood and liver function tests are advisable during prolonged treatment. **Pending further experience, like most chemotherapeutic agents, this drug should not be given in the first trimester of pregnancy. It must be used cautiously in patients with liver disease or severe impairment of kidney function.** Because photosensitivity reactions have occurred in a small number of cases, patients should be cautioned to avoid unnecessary exposure to direct sunlight while receiving NegGram, and if a reaction occurs, therapy should be discontinued. The dosage recommended for adults and children should not arbitrarily be doubled unless under the careful supervision of a physician. Bacterial resistance may develop.

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How supplied: Buff-colored, scored Caplets® of **500 mg. for adults,** conveniently available in bottles of 56 (sufficient for one full week of therapy) and in bottles of 1000. **250 mg. for children,** available in bottles of 56 and 1000.

References: (1) Based on 23 clinical papers, 1512 cases. Bibliography on request. (2) Bush, I. M., Orkin, L. A., and Winter, J. W., in Sylvester, J. C.: Antimicrobial Agents and Chemotherapy—1964, Ann Arbor, American Society for Microbiology, 1965, p. 722.

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*As many as 9 out of 10 urinary tract infections are now caused by gram-negative organisms. E. coli, Klebsiella, Aerobacter, Proteus, Paracolon or Pseudomonas[2]... However, infections of the urethra and prostate caused by non-gonococcal gram-negative organisms are believed to be less prevalent.

Dr. Culver Speaks at Hayes

Dr. John R. Culver, Oconto Falls, recently spoke at the Hayes School Parent–Teacher league. His topic was "Better Odds for a Longer Life."

Dr. Richard Friesendorf Gives Talk

Dr. Richard E. Friesendorf, assistant chief of cardiology at the Veterans Administration Hospital in Milwaukee, recently spoke on blood pressure, strokes, and heart disease at the Jewish Community Center at Milwaukee.

Dr. G. G. Mueller Featured Recently

Dr. Gustav G. Mueller, Princeton, was recently featured in the OSHKOSH NORTHWESTERN for his selfless service to the Princeton area. Doctor Mueller graduated from the medical school of the University of Minnesota in 1925 and practiced at Windom, Minn., before returning to his home town in 1930. He has two sons who are doctors; *Dr. Gustav C. Mueller* is a chest and vascular surgeon at Quisling Clinic, Madison, and Dr. Robert A. Mueller, a resident at Minneapolis, Minn. Doctor Mueller's wife has assisted him in his office and on house calls.

Dr. Gallagher Author of Vietnam Feature

Dr. Wm. B. Gallagher, La Crosse, recently wrote an article on his experiences in Vietnam and was featured in the St. Francis Hospital quarterly review. Doctor Gallagher was stationed in Bac Lieu for nine weeks, in the lower Mekong Delta in September and October 1966.

Dr. Kincaid Speaks on Venereal Disease

Dr. Charles K. Kincaid, director of the Madison City Health Department, recently told an audience of teenagers and adults that a lot of private laboratories are concealing information about carriers of venereal disease. Doctor Kincaid emphasized the fact that it is important for the Health Department to know of cases so that a complete examination of all persons involved may be made.

Dr. Chase Speaks on Heart

Dr. Jules Chase, Milwaukee, assistant clinical professor of medicine at Marquette University School of Medicine, recently gave a talk on heart disease prevention at the Jewish Community Center in Milwaukee.

UW Alumnus Elected to Office, San Diego

Dr. John F. Wanless, a graduate of the University of Wisconsin Medical School, was recently installed as the 1967 president of the San Diego (Calif.) County Medical Society. Doctor Wanless has been in the practice of medicine in San Diego since 1946.

Physicians whose names appear in italics are members of the State Medical Society.

NEWS OF WISCONSIN PHYSICIANS

Dr. Organick New Assistant Dean at Marquette

Dr. Avrum B. Organick, Milwaukee, has been appointed to the position of assistant dean for continuing education at Marquette University School of Medicine. Doctor Organick is also assistant coordinator for the Wisconsin Regional Medical Program. The two positions are closely related since both involve continuing education for physicians. Doctor Organick graduated from City College of New York in 1947 and received his M.D. from Cornell University Medical College in 1951. His residency training in internal medicine was taken at Massachusetts General Hospital and the New York Hospital and completed in 1957. He has held academic appointments in medical colleges at Harvard University, Cornell University, University of Colorado, and Baylor University. He was chief of tuberculosis, Navajo Medical Center, Fort Defiance, Arizona, 1954–56, and chief, tuberculosis unit, Denver General Hospital, 1957–59. While in military service, 1959–61, he was chief, communicable disease service, Brooke General Hospital, Fort Sam Houston, Tex.

Doctor Organick is a member of the American Thoracic Society, American Federation for Clinical Research, American Association for the Advancement of Science, American Society for Microbiology and was president, Milwaukee Research Club, 1964–66.

Dr. Korst Speaks at Madison General Hospital

Dr. Donald Korst, Director of Medical Education at Madison General Hospital, spoke recently on "Medical Education in the Community Hospital," at the hospital's annual meeting.

Dr. Bunke Speaks on Family Planning

Dr. John Bunke, Waukesha, an obstetrician and gynecologist on the staff of the Planned Parenthood Assn. Clinic, recently spoke in Wauwatosa at a Natural Childbirth Association meeting on the development of family planning methods and described the type of medical care and supervision available to each patient at the clinic.

Dr. Bachhuber Speaks at Mayville

Dr. Michael Baehhuber of Mayville recently spoke to a group of homemakers and their guests from Mayville, Horicon, and Watertown on the subject of cancer.

Dr. William Gallagher, La Crosse Reporting from Vietnam

Dr. William B. Gallagher, a general surgeon in La Crosse, volunteered for the AMA's Project Vietnam and was assigned to spend his 60-day tour at the provincial hospital in Bac Lieu in the Mekong Delta region. Here are excerpts of his impressions, as related to MEDICAL WORLD NEWS and printed in its Feb. 10, 1967 issue, at page 67.

I'M NOT SURE exactly what I expected to find here, but I certainly wasn't prepared for what I did find. We have 210 beds at Bac Lieu, and an average census of more than 300 patients, which means two in many beds. The wards always look even more crowded than that, because of the many relatives who stay with the patients.

Sometimes, the relatives create confusion. The other day, I saw a little girl with a cleft lip, took her into the OR, and repaired it. Only afterward did I find out that she wasn't a patient at all—she was just in the hospital to visit her grandfather!

. . . We've had to rely entirely on fluoroscopy, or on that much-abused term, clinical judgment. It may be fortunate that the Vietnamese are so small and thin. You can palpate quite small tumors manually. And you just go in when you must.

. . . Dr. Vinh and I do the surgery. Out of sheer necessity, I find myself doing many things I wouldn't dream of tackling at home. There are a large number of appendectomies, almost all of them ruptured because we never get to see the patient until he has been sick for days. . . .

The war casualties, who make up about 40% of our patient population, are the roughest, emotionally. . . . In our hospital, we have baby amputees, paraplegic little boys, burned girl children, and old women mangled by shell fragments. Surprisingly, the Vietnamese—outwardly at least—don't seem to resent those who injure them, no matter which side does it.

. . . Our worst problem of all is blood. We have no blood bank and we're supposed to get the blood we need from the patient's relatives. . . . I had one little boy who had been shot through the bowel. It took me 36 hours to talk his family into giving blood.

Finally, one of them gave 300 cc but it was too late. The child died. Seeking a crumb of consolation, I thought we could use at least the remaining blood for someone else. Not so. The boy's family insisted that it was *their* blood, and they took it home with them.

When people ask why I came here, I'm not sure I can give a very good answer. There's curiosity in it, a sense of adventure, a desire to help, of course.

It's been an extraordinary experience. I've seen and done and learned things that could never have been possible at home. And in spite of the worst that can be said, I'm glad I came.

PHYSICIAN NEWS *continued*

Dr. John Markson Speaks at Public Forum

Dr. John Markson, Milwaukee, recently spoke at a public forum sponsored by the YWCA of Greater Milwaukee on the sexual morality facing teenagers and the problem of unwed mothers in Milwaukee County.

Dr. Samp to Speak at Dairyland Program

Dr. Robert Samp, Madison, assistant professor in the Department of Surgery, University Hospitals, will be the guest speaker at the Alice in Dairyland program in Menomonie on May 20. He is interested in health education, disease prevention, human relations and all aspects of sensible habits and is also director of the student health education program at the University of Wisconsin–Madison.

Dr. Falk Reports on Vietnam

Dr. Victor Falk, Edgerton physician, recently spoke before a meeting of the Second District Nurses Association on his experiences in Vietnam.

Dr. Davis Attends Mid-Winter Seminar

Dr. Matthew D. Davis, University of Wisconsin, department of surgery, Madison, participated in the mid-winter Seminar of Ophthalmology and Otolaryngology at the University of Miami School of Medicine. Doctor Davis presented two papers: "Diabetic Retinopathy II—Proliferative Retinopathy and Vitreous Contraction" and "The Natural Course of Retinal Tears Without Detachment."

Dr. Rusch Says Cancer Research Encouraging

Dr. Harold P. Rusch, Director of the McArdle Laboratory for Cancer Research, Madison, recently said, "that now almost one-third of all cancer patients are cured and not too long ago relatively few were cured." McArdle researchers are engaged in three broad approaches to the study of cancer. The first approach concerns the biochemical nature of cell changes that make a normal cell cancerous; the second approach is in the field of genetics or heredity and *Dr. Gerald C. Mueller* is investigating substances which inhibit or encourage cell division. The third approach to cancer at McArdle, scientists are attempting to pinpoint the differences between normal and cancerous cells. Dr. H. C. Pitot has demonstrated that cancer cells lose the capacity to form certain enzymes which are formed by normal cells.

Dr. Merrill Named Chief of Medicine

Dr. Robert S. Merrill has been named Chief of Medicine at the Veterans Hospital in Tomah. He has been in active medical service since October 1963.

Dr. A. J. McCarey Announces Retirement

Dr. Arthur J. McCarey, Green Bay physician since 1919, recently announced his retirement. Doctor McCarey is a former president of the State Medical Society of Wisconsin and was honored in 1962 for his 50 years of membership in the Society. He was a founder of the Wisconsin Surgical Society and helped establish the Museum of Medical Progress at Prairie du Chien. He has been vice-president of the Society's Charitable, Educational & Scientific Foundation for a number of years. Doctor McCarey wrote many articles on the medical history in northeastern Wisconsin and one of them "A Historical Summary of Medical Progress in Wisconsin" appeared in the WISCONSIN MEDICAL JOURNAL in May 1958. He served in World War I, was awarded the Purple Heart and also received a commendation from General John Pershing.

Dr. A. J. McCarey

Dr. William Gallagher Guest Speaker

Dr. William Gallagher, La Crosse, recently spoke on his nine weeks of volunteer service in Vietnam to the members and their guests at a Navy League Annual dinner in La Crosse. He commented that there were 40,000 amputees in South Vietnam and only a few hundred a month could be fitted with artificial limbs.

Dr. Dewitt Speaker at Hospital Auxiliary

Dr. Robert Dewitt, Marinette, was the guest speaker at a meeting of the Marinette General Hospital Auxiliary this month.

Appleton Doctors Named to Advisory Committee

Drs. T. M. Loescher, C. E. Fenlon, and *Francis M. Hauch* of the Outagamie County Medical Society were named to the Advisory Committee to counsel the Appleton Council in carrying out long-range municipal improvements.

Dr. Forster Speaks at MS Clinic

Dr. Francis M. Forster, chairman of the neurology department, University of Wisconsin Medical School, recently spoke at a meeting of the Wisconsin Chapter of the National Multiple Sclerosis Society.

Drs. Krohn and Holder Present Lessons

Drs. Robert Krohn and *Richard Holder* of the Krohn Clinic in Black River Falls and William Wilcox, administrator of the Krohn Clinic, recently presented lessons in recent advances in the medical field to a group of home economists in Black River Falls.

Wisconsin Physicians Receive AMA Appointments

Dr. Wesley W. Hall, chairman of the AMA's Board of Trustees, recently announced the reappointments of the following physicians to committees for the American Medical Association. They are as follows: *Drs. Armand J. Quick*, and *Anthony V. Pisciotta*, Milwaukee, have been reappointed as members of the Subcommittee on Hematopoietic and Lymphatic Systems of the American Medical Association's Committee on Rating of Mental and Physical Impairment; *Dr. Francis M. Forster*, Madison, to the Committee on Rehabilitation of the AMA; *Oscar A. Sander*, Milwaukee, reappointed a member of the Committee on Rating of Mental and Physical Impairment; *Allan J. Ryan*, Madison, *James C. H. Russell*, Fort Atkinson, the Committee on Exercise and Physical Fitness; and, *Ewald Pawsat*, Fond du Lac, has been reappointed a member of the Council on Voluntary Health Agencies.

Dr. Woloschek Addresses Hospital Auxiliary

Dr. W. J. Woloschek of Milwaukee, vice-chief of staff of West Allis Memorial Hospital, a diplomate of the American Board of Surgery, fellow of the American College of Surgery, and an originator of St. Mary's Burn Center, recently discussed burns at the annual meeting of the West Allis Memorial Hospital Auxiliary.

Dr. Laird Addresses the Press

Dr. James Laird, Appleton health commissioner, recently proposed to the press to incorporate into the educational system of Appleton the subject of venereal disease.

Hypnosis May Curb Madmen, Physician Claims

Dr. William J. Bryan, Jr., Los Angeles, executive director of the American Institute of Hypnosis, was in Milwaukee recently to conduct a course on the use of hypnosis in the medical, dental, and legal professions. During his lecture he informed the group that hypnosis some day could be used to protect communities from criminals and mentally deranged persons by implanting posthypnotic suggestions that would render them harmless.

UW Kidney Transplanters Report Success

An extensive research program in transplanting kidneys from one body to another at University Hospitals, Madison, appears to be achieving some success. A research team has completed five successful transplants in the last year and the sixth took place recently and also appears to be a success. *Dr. William A. Kisken*, Madison, was the chief surgeon in the recent transplant.

Dr. Peckham Named UW Associate Dean

Dr. Ben M. Peckham, professor of gynecology and obstetrics, was named associate dean of the University of Wisconsin Medical School in February.

Dr. J. W. McGill, Superior, Retires

After 40 years of medical practice at Superior, *Dr. James W. McGill* retired in February. Following his retirement the Douglas County Medical Society and the three Superior hospitals arranged occasions at which he could be honored and recognized for "40 years of selfless service as a dedicated physician and an outstanding example of a Christian gentleman."

On March 1, the Douglas County Medical Society honored Doctor McGill at a testimonial dinner during which the colorful 40-year career in the medical profession was reviewed. C. H. Crownhart, secretary of the State Medical Society, was guest speaker.

Superior's three hospitals—St. Mary's, St. Joseph's, and Superior Memorial—paid special tribute to the retiring doctor at a banquet March 16 at St. Mary's Hospital. Being the day before St. Patrick's Day, the Irish theme prevailed. *Dr. James P. McGinnis* was toastmaster and remarks were given by the Rev. Robert M. Urban, *Dr. V. E. Ekblad*, and *Dr. H. A. Sincock*. Presentations were given by Sr. M. Immaculata of St. Joseph's Hospital, Charles Laible of Superior Memorial Hospital, and Sr. M. Clarice of St. Mary's Hospital.

Following graduation from St. Louis University Medical School in 1925, Dr. James W. McGill began his medical career in 1926 in association with his father, the late Dr. P. G. McGill who had begun his practice in 1891. The father–son practice continued until the early 1930s when the senior McGill retired. The younger doctor maintained a private office until the opening of the Superior Clinic in 1965.

Doctor McGill's medical interests have extended beyond patient care. He has served as president of numerous organizations, including the Douglas County Medical Society and the Interurban Academy of Medicine and has been chief of staff at both St. Mary's and St. Joseph's hospitals.

He is a member of several local, state, and national medical groups.

He is recognized not only for his medical abilities but also as an outstanding elocutionist and in his college days was nicknamed, "The Senator."

Doctor McGill has been active in many local civic groups and has taken a leading part in religious organizations. Recognition of his service came in 1955 when Pope Pius XII conferred upon him the Pontifical Honor of Knight of the Order of St. Gregory the Great. It is the highest honor presented by the Catholic Church to a layman.

At the State Medical Society Council meeting March 11–12, he was voted an honorary member of the Society in acknowledgment of his stellar services to medicine and to his community. There are only eleven other honorary members of the Society.

Dr. Kennedy Named Pediatric Diplomate

Dr. John Kennedy, pediatrician at the Rice Clinic, Stevens Point, has been recently named a diplomate of the American Board of Pediatrics after a recent examination in Chicago. Doctor Kennedy has been practicing in Stevens Point a year. Prior to that he practiced several years in Maine. He is a graduate of Beloit College and the University of Michigan Medical School where he also took his specialty training.

Doctors Become Board Certified

Dr. James Algiers, internist, and *Dr. Robert J. Nickels*, general surgeon, both of Hartford, were recently board certified in their respective specialties.

Photo courtesy SUPERIOR EVENING TELEGRAM

RECEIVING CONGRATULATIONS UPON HIS RETIREMENT after 40 years of medical practice is Superior physician, *Dr. James W. McGill* (center). Others who helped celebrate the occasion are *Dr. T. J. Dayle*, co-chairman of the banquet; C. H. Crownhart, secretary of the State Medical Society of Wisconsin; Doctor McGill; *Dr. Fred Johnson*, co-chairman of the banquet; and *Dr. Enzo Krahl*, president of the Douglas County Medical Society who arranged the testimonial.

Physicians, Back from Vietnam, Interviewed on Television

EARLY IN FEBRUARY, three Wisconsin physicians and a medical student appeared on WHA–TV's "University of Wisconsin Roundtable" to describe their experiences in Vietnam. Two of the physicians, *Dr. V. S. Falk* of Edgerton and *Dr. C. E. Hopkins* of Madison, and student, Bernard Marquardt, spent 60 days in civilian hospitals under the AMA's program "Volunteer Physicians for Vietnam;" the third, *Dr. Anthony Curreri*, director of University of Wisconsin's Division of Clinical Oncology, made a survey of military medical facilities there for the United States Surgeon General's office.

Above: Doctors Falk; Hopkins (hidden—shown at the right); Mr. Ray Vogelman, news director of WHA and program moderator; Mr. Morquardt, and Doctor Curreri view slides, which Doctor Hopkins took, on the station monitor. The program was also carried on two rebroadcasts throughout the State Radio Network. Arrangements were made through the State Medical Society's Communications Department.

Dr. Shropshire: "Mission Critic"

Dr. Richard W. Shropshire of Madison, a general practitioner at the Monona Grove Clinic, and his wife recently returned from a 30-day tour of missions, hospitals, schools, villages, and cities in India. The doctor was sent to India as a part of a "Mission Interpreter" program of the United Church Board for World Ministries for the United Church of Christ. He was the first U. S. layman to go into the church's mission field abroad. The Asian trip was financed by a private grant given to the UCC Church to conduct an in-depth study to obtain an understanding of its foreign missions.

SMS Council Appointments

At the March 11–12 meeting of the Council of the State Medical Society at its headquarters in Madison the Council initiated or approved the following appointments: *Dr. George Stebbins* of Madison to chairmanship, Division on Aging of the Commission on State Departments; *Dr. E. E. Houfek* of Sheboygan to vice-chairmanship, Division on Nervous and Mental Diseases of the Commission on State Departments; *Dr. L. W. Schrank* of Waupun to Commission on Hospital Relations and Medical Education; *Dr. James A. Sisk* of Fond du Lac as SMS representative to Health Service Data of Wisconsin, Inc., Milwaukee-based, nonprofit agency providing health facilities computerized data for use in utilization and quality control; and *Dr. Ralph Frank* of Eau Claire to State Board of Health's Interagency Council on Smoking and Health.

Madison General Hospital Names Chief

The medical staff of Madison General Hospital recently elected *Dr. Henry M. Suckle* as chief-of-staff. Others elected were *Dr. James F. Land*, vice-chief-of-staff; *Dr. James F. McIntosh*, secretary–treasurer; and *Dr. Charles A. Doehlert*, representative to the Dane County Medical Society.

Dr. Parsons Featured in Know Your Madisonian

Dr. William B. Parsons Jr., director of research for the Jackson Foundation as well as a member of the department of internal medicine at the Jackson Clinic in Madison, recently was honored in a Madison newspaper. Doctor Parsons has spent a dozen years in research on the prevention of heart attacks by controlling cholesterol through drugs and recently embarked on a new seven-year study of the problem. This project will eventually involve 50 medical centers and is part of a nationwide heart study being financed by the National Institutes of Health.

MEMORIAL GIFTS . . . .

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COUNTY SOCIETY PROCEEDINGS

BROWN

The second series of immunization clinics for rural Brown County children was started in February. Three-in-one vaccines for DPT were given children three months to six years of age. Two-in-one vaccines for DPT will be given to those six and older. Smallpox vaccinations, given at one year old and every five years, also will be available.

CHIPPEWA

Guest speaker at the March 7 meeting of the Chippewa County Medical Society in Chippewa Falls was *Dr. Marc Hansen*, pediatrician of University Hospitals, Madison, who spoke on the subject, "The Role of the Computer in the Future of Medicine."

COLUMBIA–MARQUETTE–ADAMS

A Marquette county war on red measles was staged in late February when teams of physicians, nurses, medical technicians, and volunteer helpers set up clinics to administer the measles virus vaccine free of charge to all children under the age of 12, who had not had red measles or previous immunization.

The program was sponsored by the Tri-County Medical Society and organized by the Marquette county nurse, Mrs. Dorothy Peterson. Working with Mrs. Peterson in the clinics were Dr. Donald Mitchell, Madison, State Board of Health; *Dr. G. G. Shields*, district health officer of the State Board of Health; and William Gilbert, immunization program coordinator of the section on preventable diseases of the State Board of Health.

DANE

There was no meeting of the Dane County Medical Society in March. At its February meeting, the Society endorsed the implied consent part of Gov. Warren Knowles highway safety program. The vote was almost unanimous in favor of the proposal which would force a suspected drunk driver to submit to an alcohol content test or lose his license for three months. The Society sent letters calling attention to its endorsement to the governor and legislators.

New members of the Society are: *Dr. Bruce R. Holzman* and *Dr. Harry Roth*, both of Madison. Doctor Holzman was born at Evanston, Ill.; received his medical education from Northwestern University Medical School; interned at Cook County Hospital in Chicago; and is now a resident in psychiatry at the University Hospitals.

Doctor Roth was born in Dayton, O.; received his medical education at Western Reserve University School of Medicine in Cleveland; interned at Cincinnati General Hospital, Cincinnati, O.; did postgraduate work at the University of Wisconsin Hospitals; and is currently an ophthalmology resident at University Hospitals.

Physicians whose names appear in italics are members of the State Medical Society.

DODGE

The Dodge County Medical Society met in Beaver Dam February 23 with 14 members present. Earl Thayer, a former assistant secretary of the State Medical Society and currently acting as secretary of PACE—Professional Association for Civic Education—was the speaker. He urged members of the Society to become interested in political action and join those physicians who feel that the solution to better government lies in electing men to office who share their philosophies and ideals.

DOUGLAS

The Douglas County Medical Society participated in sponsoring the visit of the State Board of Health Mobile Survey Unit in Superior and Douglas County the latter part of February and March. Screening tests for diseases of the heart and lungs, high blood pressure, and diabetes were conducted.

GREEN

An adult tetanus immunization program sponsored by the Green County Medical Society and the Green County Health Committee, was conducted in February and March by the Green County public health nurses, Mrs. Martha Tschudy and Mrs. Nan Diedrick. Local physicians administered the "shots." A fee of $1.00 was charged for each immunization. Proceeds were to be donated to the St. Clare Hospital Building Fund. People who had attended the tetanus immunization program in the fall of 1962 were urged to return for their booster dose.

GREEN LAKE–WAUSHARA

Dr. George Lysloff, director of research and education at Winnebago State Hospital, spoke on trends in the treatment of alcoholism in the state at the Green Lake–Waushara County Medical Society February 16 at Oshkosh.

JEFFERSON

Immunization for diphtheria, whooping cough, and tetanus is being given at a number of clinics in Jefferson County this spring. Oral polio immunization is also available at the clinics. Cost for

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diphtheria, whooping cough, and tetanus is 50¢ per injection. Adult tetanus toxoid is 75¢ per injection. Oral polio vaccine is $1.00 for each dose. This service is free for those who are unable to pay.

The program is being conducted by the Jefferson County public health nurses, and the Fort Atkinson school nurse with the cooperation of the Jefferson County Medical Society. Clinics are being held during March, April, and May.

KENOSHA

Immunization clinics for rural area children have been scheduled during March, April, and May under the direction of the Kenosha County nurse. Physicians who are members of the Kenosha County Medical Society are administering the immunizations for diphtheria, whooping cough, tetanus, polio, and smallpox.

PIERCE–ST. CROIX

Dr. F. B. Klaas, Ellsworth, is the newly-elected president of the Pierce–St. Croix County Medical Society. President-elect is *Dr. George J. Hopkins* of Hudson. *Dr. C. A. Olson* of Baldwin is the secretary–treasurer.

Dr. F. B. Klaas

Doctor Klaas is an active member of the society and has served on the nurses scholarship committee and other committees. He was chairman of the Bi-County Polio Immunization program; he is chairman of the Ellsworth campaign for the Wisconsin Heart Association, and is coroner of Pierce County. He graduated from Marquette University School of Medicine.

Immunization clinics were held in the Pierce–St. Croix area during March by the Public Health Nursing Service in cooperation with the Pierce–St. Croix County Medical Society.

STATE MEDICAL SOCIETY SUPPORTS VOLUNTARY STATEWIDE IMMUNIZATION PROGRAM TO ELIMINATE MEASLES

The State Medical Society is supporting a Substitute Amendment 2, A. to Assembly Bill 143 which would direct the State Board of Health to carry out a statewide immunization program to eliminate measles. The Substitute Amendment also states that preschool children and any other persons susceptible to measles shall be encouraged to become immunized against the disease and that there shall be no charge to the persons immunized for the cost of the vaccine furnished by the Board of Health.

The Society is opposed to mandatory immunization as stated originally in Assembly Bill 143. It has endorsed the educational program of the Wisconsin Jaycees and the Wisconsin Association for Retarded Children who have declared April as "End Measles" month. Their objective in an organized campaign is "to reach every family in your county with the facts about measles and the news that the vaccines are easily available and to get them to consult their physicians." Although the "war on measles" was declared in April, the emphasis on eradication of the potentially crippling disease will continue indefinitely. The Society is assisting the Jaycees and Wisconsin ARC by preparing news releases, radio spot announcements, and the like.

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COUNTY SOCIETIES *continued*

PRICE–TAYLOR

Countywide measles vaccination centers in Price county were set up during March by the county public health nurse, Charlotte France. Children between the ages of nine months through five years were the target group. The Price–Taylor County Medical Society, Price County Association for Retarded Children, and the Price County Public Health Nursing Service are cooperating.

SHAWANO

Immunizations covering diphtheria, pertussis, tetanus, diphtheria–tetanus, smallpox, and polio were offered school-age children during clinics set up in February by the Shawano County public health nurse in cooperation with the Shawano County Medical Society.

TREMPEALEAU–JACKSON–BUFFALO

The psychoactive compounds in the general practice of medicine were discussed by *Dr. J. M. Tobin* at the March 28 meeting of the Tri-County Medical Society. Doctor Tobin is a member of the Northwest Psychiatric Clinic at Eau Claire. Members wives were guests.

SMITH KLINE & FRENCH LABORATORIES FOREIGN FELLOWSHIPS AWARDED

Two Wisconsin medical students have been awarded foreign fellowships which will permit them to assist for 12 weeks this summer at a mission hospital in Africa. They are among 31 American medical students selected to receive Smith Kline & French Foreign Fellowships from the Association of American Medical Colleges. The fellowships are supported by a grant from the Philadelphia prescription drug firm.

Richard A. Ellingstad, a junior in the University of Wisconsin Medical School, Madison, has been awarded $2,880. He and his wife, a registered nurse with public health training, leave in June for Kiomboi Lutheran Hospital, Kiomboi, Tanzania, East Africa, where they will work under the supervision of Dr. Frederick M. Wilcox, medical director. Mr. Ellingstad is a native of Hudson.

Bradley T. Hales, a junior in the University of Chicago School of Medicine, has been awarded $1,404. A native of Madison, he will leave in June for Holy Family Hospital at Berekum in Ghana, West Africa, where he will work under the supervision of Sister Marie Therese, the hospital administrator.

Now entering its eighth year, the SK&F Foreign Fellowships program was established to permit American medical students to widen their medical horizons in cultures very different from their own.

WALWORTH

Thirty members of the Walworth County Medical Society and their wives met February 16 in Delavan. Mrs. Delores Long, RN, of the Walworth County nurses office, Elkhorn, spoke to the group on the Visiting Nurses Association. Her title was "Home Nursing Care Program."

WAUKESHA

The February meeting of the Waukesha County Medical Society was held in Waukesha at the Waukesha County Institutions. A lecture by members of the various departments at the County Institutions and the Welfare Department, concerning the functions of the County Institutions and their departments, was conducted.

WAUPACA

The February 23 meeting of the Waupaca County Medical Society was held in New London with 10 members present. *Dr. Paul R. Glunz* of Beaver Dam was the guest speaker. His subject was "Drug-induced Liver Disease."

During the business session a clinic for measles vaccine immunization was approved and a future date was to be set by the county and city health nurses.

In cooperation with the Waupaca County Medical Society, a countywide tuberculin skin testing program was held the latter part of February and into March. School children in the first and fourth grades were offered the free tests at the clinics which were conducted by the Waupaca county nurse.

WINNEBAGO

The Winnebago County Medical Society held its March 2 meeting at the Valley Inn in Neenah. Guest speaker was a pediatrician, *Dr. Marc Hansen*, of the University of Wisconsin, who talked on the subject, "The Use of Computers in the Practice of Medicine."

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Milwaukee Branch, WPA

The Milwaukee Branch of the Wisconsin Psychiatric Association met March 1 at the Milwaukee Psychiatric Hospital which was host for the meeting, an annual custom.

Dr. Samuel Black of Milwaukee introduced the guest speaker, Dr. Morris Slansky, who is a psychoanalyst from Chicago and who has a particular interest in adolescent problems. His topic was "Character Disorder Entities of Adolescence and Their Treatment."

Milwaukee Academy of Medicine

The 933rd meeting of the Milwaukee Academy of Medicine was held March 21 at the University Club of Milwaukee. Dr. Robert P. Heaney, professor and chairman of the Department of Medicine, Creighton University School of Medicine, Omaha, Neb. was the guest speaker who discussed "Osteoporosis: Emerging Concepts of Bone Metabolism."

Physicians whose names appear in italics are members of the State Medical Society.

SPECIALTY SOCIETY PROCEEDINGS

Milwaukee Gastroenterological Society

New officers recently elected to the Milwaukee Gastroenterological Society for 1967–1968 are as follows: president, *Dr. Miles B. Smith;* vice-president, *Dr. Walter P. Stenborg;* and secretary–treasurer, *Dr. Michael A. Polacek*, all of Milwaukee.

Milwaukee Ophthalmological Society

Dr. Ralph E. Teitgen of Milwaukee reviewed the Constitution and Bylaws of the Milwaukee Ophthalmological Society at its February 28 meeting at the University Club of Milwaukee.

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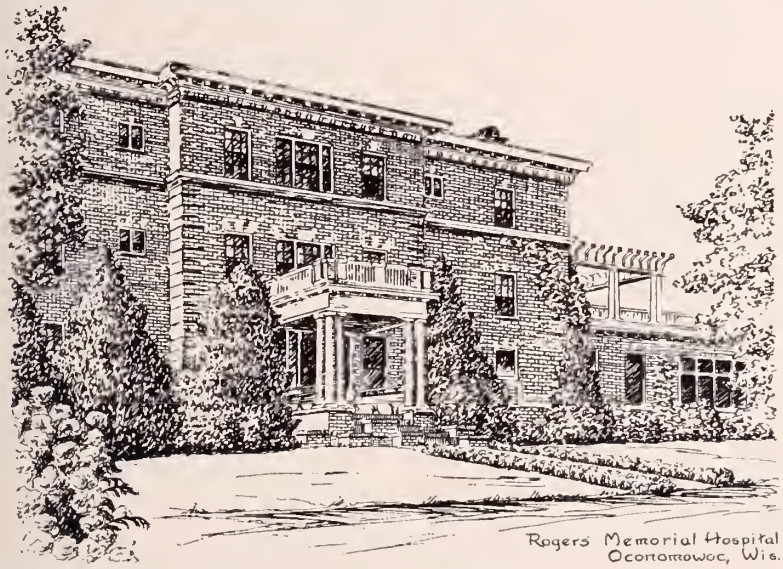

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THOMAS J. GORAL, M. D.
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Two Surveys Describe the Effects of Medicare on Milwaukee Area Hospital Utilization

SIXTEEN MEMBER hospitals of the Hospital Council of Greater Milwaukee reported that they have admitted a total of 15,862 Medicare patients as of Jan. 31, 1967, according to a recent survey conducted by the Council.

The survey also disclosed that there were a total of 1053 Medicare patients in these 16 hospitals on Jan. 31, 1967, as compared with a total of 916 Medicare patients in the hospitals on the day the Medicare program went into effect (July 1, 1966). Eight of the reporting hospitals also indicated that they had a total of 54 Medicare patients waiting for admission on Jan. 31, 1967.

The Hospital Council's report further indicated that 31.3% of all medical–surgical patients at these 16 hospitals on Jan. 31, 1967, were Medicare beneficiaries. This proportion can be compared with the fact that Medicare patients represented 24.0% of all medical–surgical patients in the same hospitals on July 1, 1966. As of Jan. 31, 1967, six of the reporting hospitals indicated total medical–surgical occupancy figures of more than 90%; six reporting hospitals were in the 80% to 90% occupancy range; three of them were in the 70% to 80% occupancy bracket; and one hospital reported a medical–surgical occupancy of less than 70%.

As part of its continuing responsibility to monitor hospital utilization throughout Milwaukee, Ozaukee, Washington, and Waukesha counties, Hospital Area Planning Committee has also recently released a report that indicates the ability of area hospitals to handle the demand for beds created by Medicare.

Data from the monthly reports of 17 hospitals in the four-county area show discharges and discharge patient days as percentages of total discharges and total patient days for the six-month period beginning in May 1966, as follows:

In its analysis, HAPC also compared actual utilization of 20 hospitals in the four-county area during a three-month period of 1966 with the same period in 1965. This analysis indicated that these 20 hospitals provided a total of 265,035 medical-surgical (including pediatrics) patient days of care during September, October, and November of 1966. This total was 0.8% higher than the 262,840 patient days of care provided by the same hospitals during the same period of 1965. The overall percentage of medical-surgical occupancy in the hospitals for the three-month period of 1966 was 77.6. This compared with a medical-surgical occupancy percentage of 77.3 during the same period of 1965.

The HAPC report points out, however, that the largest hospital included in these utilization figures, Milwaukee County General Hospital, experienced a 12.7% decrease in total medical-surgical patient days —from 46,134 patient days during the three-month period in 1965 down to 40,285 patient days during the same period of 1966.

In announcing these surveys, officials of both the Hospital Council of Greater Milwaukee and Hospital Area Planning Committee pointed out the importance of continually monitoring the impact of Medicare upon the demand for hospital beds. Spokesmen for both organizations emphasized, however, that the data disclosed in these reports can scarcely be considered true indicators of the future impact of Medicare upon utilization of area hospitals. Considerably more experience with the effects of this legislation will have to be gained, normal seasonal fluctuations will have to be considered, and the other factors that affect use of hospitals will have to be taken into account before a clear pattern can be discerned.

	May	June	July	Aug.	Sept.	Oct.	Nov.
Discharges Over Age 65 as a % of Total Discharges	15.1	16.3	17.4	17.2	17.9	17.5	19.1
Discharge Patient Days by Patients Over 65 as a % of Total Discharge Patient Days	22.2	27.5	28.0	29.2	30.6	28.7	29.3

The HAPC report also analyzed the proportion of total discharges and total discharge patient days attributable to patients 14 years of age and under. This analysis was done in order to take into account the possibility that Title 19 of the federal program (Medicaid) might have had some impact upon hospital use. The results for the same six-month period in 18 area hospitals were as follows:

	May	June	July	Aug.	Sept.	Oct.	Nov.
Discharges Age 14 and Under as a % of Total	21.1	24.5	23.5	24.8	21.0	19.1	22.5
Discharge Patient Days Age 14 and Under as a % of Total	14.8	15.8	15.4	15.6	13.6	13.0	15.4

National Association of Medical Examiners

Formation of the National Association of Medical Examiners to advance the administrative, career, and other practical interests of the country's medical examiners has been announced by Milton Helpern, MD, Chief Medical Examiner of New York City and Interim President of the new organization.

Doctor Helpern said the Association will seek to deal with such problems as the need for greater understanding and support for the medical examiner system from the general public, government officials at all levels and the medical and legal professions, and the need for a greater exchange of information and opinion among medical examiners.

Physicians who are interested in the new organization and believe they are qaulified to belong are invited to write to: National Association of Medical Examiners, 520 First Avenue, New York, N. Y. 10016.

Public Arthritis Forum, Kenosha

The Racine and Kenosha County Arthritis Action Committees, in cooperation with the Arthritis Foundation of Wisconsin, sponsored a public arthritis forum March 15 at the Wisconsin Electric Power Service Hall in Kenosha.

Dr. Edwin C. Welsh, a specialist in physical medicine and director of the Physical Medicine and Rehabilitation Department at St. Luke's Hospital in Milwaukee, was the featured speaker.

The program included the Arthritis Foundation's new film, "The Five Faces of Arthritis," depicting the stories of five patients from five different walks of life and each with a different form of arthritis.

Interagency Council on Smoking and Health

Tobacco taxes and current trends, including the bootlegging of cigarettes and enforcement problems, were discussed at a meeting of the Wisconsin Interagency Council on Smoking and Health held March 16 at The Abbey, Fontana. *Dr. Glenn A. Smiley*, Delavan, is chairman of the Council.

Russell Herron, chief tax examiner of the Division of Beverage and Cigarette Taxes of the Wisconsin Department of Taxation, was guest speaker and he reported on cigarette consumption in the state.

Among other items on the agenda was the assignment of members of the board of directors to the four standing committees called for in the organization's bylaws.

COMMITTEE ON CHILDREN AND YOUTH EDUCATION. Miss Luida Sanders of the Department of Public Instruction is chairman. Leslie Johnson, who is superintendent of schools at Sheboygan and who represents the Wisconsin Congress of Parents and Teachers, is vice-chairman. Members are Mrs. Richard Bakke of the Department of Public Welfare; Edward M. Keller, D.O. of Beaver Dam and representing the Wisconsin Association of Osteopathic Physicians and Surgeons; and *Robert J. Samp, M.D.* of the University of Wisconsin Medical School.

COMMITTEE ON ADULT EDUCATION. *Ralph C. Frank, M.D.* of Eau Claire and representing the State Medical Society of Wisconsin is chairman. Vice-chairman is *Arthur L. Van Duser, M.D.* of the State Board of Health. Members are Miss Beatrice K. Palen, R.N. of the Wisconsin Board of Vocational, Technical and Adult Education; and *David J. Carlson, M.D.* of Milwaukee and representing the Milwaukee Division of the American Cancer Society.

COMMITTEE ON PROFESSIONAL EDUCATION. *Joseph W. Rastetter, M.D.* of Milwaukee and representing the Marquette University School of Medicine is chairman. Roger Hamilton of the Wisconsin Hospital Association is vice-chairman and the members are Miss Agnes Donermeyer, R.N. of the Wisconsin Nurses Association; Ralph H. Hilgert, D.D.S. representing the Wisconsin State Dental Society; and Doctor Samp.

MASS MEDIA AND MATERIALS COMMITTEE. Doctor Carlson is chairman and Joseph J. Lalich, M.D., representing the Wisconsin Heart Association, is vice-chairman. Members include Doctor Smiley, and Warren Southworth of Madison, who represents the Wisconsin Anti-Tuberculosis Association.

Physicians whose names appear in italics are members of the State Medical Society.

PARAMEDICAL ANCILLARY GROUPS

Ozaukee–Sheboygan Medical Assistants

Members of the Ozaukee–Sheboygan County Medical Assistants Society met February 28 in Sheboygan. Speaking to the group was Lt. Ray Nehrlich of Sheboygan County Sheriff's Department. His subject was "Auto Safety."

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Binard, Joseph E., 601 Reed Ave., Manitowoc 54220
Hanek, Robert D., 500 Birch St., Park Falls 54552
Holzman, Bruce R., 1351 South St., Madison 53715
Jiroch, John T., 1119 Marshall St., Manitowoc 54220
Miller, Herbert P., Jr., 2300 Western Ave., Manitowoc 54220
Myers, Robert E., 2219 Garfield, Two Rivers 54241
Roth, Harry, 2303 Chalet Gardens Rd., #112, Madison 53711
Sealby, Robert L., Shawano 54166
Thranow, John A., Jr., 106 Wilson St., Valders 54245
Utrie, John W., 1821 South Webster Ave., Green Bay 54301
Vakili, Hossein, Victory Memorial Hospital, Medford 54451

REINSTATED

McDuffie, James J., 2661 North Teutonia Ave., Milwaukee 53206

CHANGES OF ADDRESS

Alford, Gary, Beech Grove, Ind., to 3415 North Wishon Ave., Fresno, Calif. 93704
Allen, James C., Boston, Mass., to 1300 University Ave., Madison 53706
Alt, Thomas H., Neenah, to USA Disp. Dexheim, APO New York 09111, New York
Bandelin, Valerie R., Kenosha, to 9733 Oak Lane, Des Plaines, Ill. 60016
Bardenwerper, Hulbert E., Milwaukee, to 1839 Wauwatosa Ave., Wauwatosa 53213
Batson, John F., 4510 Regent St., Madison 53705
Blahnik, C. L., Peshtigo, to 159 Willow Dr., Gretna, La. 70053
Connors, D. M., 720 South Brooks St., Madison 53715
Cushman, Stephen M., Jr., Racine, to 223 South Highland Ave., Lombard, Ill.
Dohearty, William H., Wauwatosa, to 1616 West Bender Rd., Milwaukee 53217
Goetz, Roger A., Wood, to 6565 North Alberta Court, Milwaukee 53217
Grossman, Ronald E., 6999 Beechtree Dr., Milwaukee 53209
Guillermo, Remedios A., Wood, to Western Reserve University, 2065 Adelbert Rd., Cleveland, Ohio 44106
Harkness, John W., Wauwatosa, to 961 North 15th St., Milwaukee 53233
Kassowitz, K. E., 3321 North Summit Ave., Milwaukee 53211
Kowalski, Thomas H., Milwaukee to 5314 Robin Dr., Greendale 53129
Kramer, James D., 3325—11th St., Wausau 54401
Manhart, Richard A., 20 South Park St., Madison 53715
Matus, Simon, Albany, N. Y., to Box 65, Smithtown, N. Y. 11787
McDonald, Clarence F., 4073 South Lake Dr., Milwaukee 53207
Paluska, Donald J., USAF Hospital, Tachikawa, Japan, PACAF, San Francisco, Calif. 96323
Rauch, Alphonsus M., 782 South Shore Dr., Lake Geneva 53147
Shindell, Sidney, 1725 West Wisconsin Ave., Milwaukee 53233
Smuckler, Robert H., 7939 West Congress St., Milwaukee 53218
Stein, Ronald W., Sussex, to 1319 Milwaukee, Delafield 53018
Stoddard, F. J., 801 East Ravine Lane, Milwaukee 53217
Waddell, John G., 317 Knutson Dr., Madison 53704

REMOVED FROM MEMBERSHIP

Brish, Adam, Kenosha County, resigned.
Dryer, Raymond B., Columbia–Marquette–Adams County
Hatfield, Margaret E., Walworth County, resigned
Tverberg, Miltzo S., Juneau County

DEATHS

Gutzler, Philip H., Pierce–St. Croix County, Feb. 3, 1967
Burke, Charles F., Dane County, Feb. 16, 1967
Domine, Anthony Z., Dane County, Feb. 16, 1967

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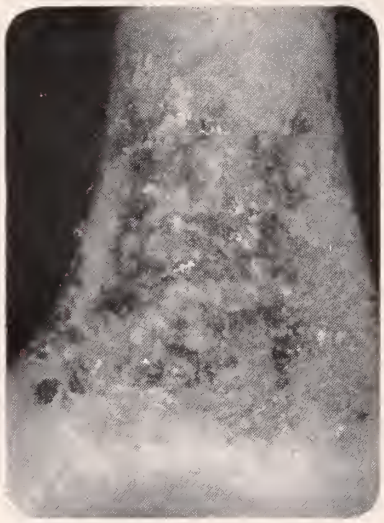

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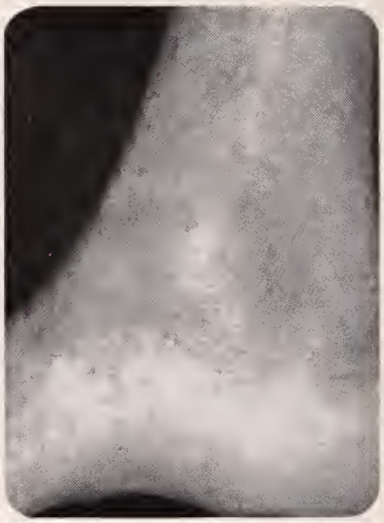

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1967 WISCONSIN

Aug. 24–26: Conference on "Current Concepts in Surgery" sponsored by the Department of Surgery, UW Medical Center, at Wisconsin Center, Madison.

Sept. 14: Adolf Gundersen Medical Foundation and Wisconsin Heart Association Symposium on Stroke, at Wisconsin State University at La Crosse.

Oct. 16–20: Wisconsin Work Week of Health, State Medical Society of Wisconsin, Madison.

Oct. 16–21: Postgraduate course, "Basic and Clinical Aspects of Therapy in Advanced Cancer," University of Wisconsin Medical Center, Madison.

Nov. 17: Medical-Legal-Industrial Symposium on "Pulmonary Diseases in Industry," sponsored by Mount Sinai Hospital, at Pfister Hotel, Milwaukee.

1967 NEIGHBORING STATES

June 1–3: Postgraduate course in anesthesiology, University of Minnesota, Minneapolis.

June 12–15: Catholic Hospital Association convention, Chicago.

June 19–21: Postgraduate course in "Clinical Applications—Recent Advances in Pharmacology," presented by the American College of Physicians, at the University of Iowa, Iowa City.

Aug. 14–18: Golden Anniversary Meeting of the American Dietetic Association, Conrad Hilton Hotel, Chicago.

Aug. 21–24: 69th Annual Meeting, American Hospital Association, International Amphitheater, Chicago.

Oct. 2–6: Annual clinical congress, American College of Surgeons, Chicago.

Oct. 4–5: Annual Midwest Interprofessional Seminar on Diseases Common to Animals and Man, University of Missouri, Columbia.

Oct. 11: Third Annual Kidney Disease Symposium, Sheraton–Chicago Hotel, Chicago.

Oct. 12–13: Head and Neck Radiology Conference, Department of Radiology, College of Medicine of the University of Illinois, Chicago.

Oct. 14–20: Annual Otolaryngologic Assembly, at Illinois Eye and Ear Infirmary, Medical Center, Chicago.

1967 OTHERS

May 3: Scientific session, American Cancer Society, Dallas, Tex.

June 12–13: Postgraduate course on Obstetrics and Gynecology, University of Colorado School of Medicine, Denver.

June 18–22: 116th AMA annual convention, Atlantic City, N.J.

June 18–22: 44th annual convention of the Woman's Auxiliary to the AMA, Atlantic City, N.J.

June 25–July 2: Fifth International Congress of Chemotherapy, Vienna.

June 26–28: Spring Clinics, Children's Hospital, Denver.

July 2–6: European Cancer Meeting, Vienna.

July 14–15: Rocky Mountain Cancer Conference, Brown Palace–West Hotel, Denver, Colo.

1968 OTHERS

Jan. 14–18: Second annual meeting of the Society of Cryo-Ophthalmology, Miami Beach, Fla.

Oct. 21–25: Annual Clinical Congress, American College of Surgeons, Atlantic City, N.J.

For listing of other meetings see the JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION.

MEDICAL MEETINGS

POSTGRADUATE COURSES

Sports and Games in Rehabilitation, Madison

A postgraduate workshop on "Sports and Games in Rehabilitation" will be conducted June 19 to July 14 at the University of Wisconsin, Madison. Coordinator is Dr. Allan J. Ryan, associate professor of physical education. Workshop leader will be Miss Veida Barclay, F.C.S.P., superintendent of rehabilitation at Putschull Rehabilitation Center, Wolverhampton, England.

Physical educators, physical therapists, industrial physicians and nurses, Armed Forces personnel, and all those interested in rehabilitation may participate in this workshop which will be conducted by resident and visiting faculty. Rehabilitation will be considered from the standpoint of those suffering from acute trauma, industrial trauma, and chronic diseases, as well as in programs of adaptive physical education.

Registration Fee (1) $50.00 per person. (2) For those taking only part of the workshop, $15.00 per week. Application can be made with the Chairman, Department of Physical Education—Women, Lathrop Hall, University of Wisconsin, Madison 53706.

Gundersen Foundation Symposium on Stroke

The Adolf Gundersen Medical Foundation and the Wisconsin Heart Association have announced that the 1967 Symposium will be held Thursday, September 14, on the subject of "Stroke." The symposium this year will be held at the Wisconsin State University at La Crosse.

There will be morning and afternoon sessions with individual papers being given during the morning (9:30 a.m. to 12:30 p.m.) and a panel discussion in the afternoon (2:30 to 4:00 p.m.).

Medical speakers, panel members, and their subjects, are as follows:

DR. JOHN MARSHALL, Neurologist to the West Middlesex Hospital, Middlesex, England, *The Significance of Management of Transient Ischemic Attacks.*

DR. JOHN S. MEYER, Professor and Chairman, Department of Neurology, Wayne State University School of Medicine, Detroit, Mich., *Cerebral Blood Flow and Metabolism in Stroke—Results of Therapeutic Trials.*

DR. IRVING S. WRIGHT, Clinical Professor of Medicine, Cornell University Medical College; President, American College of Physicians, *Anticoagulant Therapy in the Treatment of Cerebrovascular Disease.*

DR. MICHAEL E. DE BAKEY, Professor and Chairman, Department of Surgery, Baylor Univer-

sity College of Medicine, Houston, Tex., *Surgical Treatment of Extracranial Cerebrovascular Disease.*

DR. MICHAEL M. DACSO, Professor of Rehabilitation Medicine, New York University School of Medicine; President, American Academy of Physical Medicine and Rehabilitation, *Prevention of Secondary Deterioration in the Hemiplegic Patient.*

All physicians are invited to attend. Registration fee is $5. Advance registration is requested.

Advanced Cancer Course at UW

A postgraduate course on "Basic and Clinical Aspects of Therapy in Advanced Cancer" will be conducted October 16–21 at the University of Wisconsin Medical Center.

Purpose of the course is to demonstrate the practical clinical application of laboratory science discoveries in anti-cancer therapy. Rounds, lectures, seminars, conferences, and discussions will be utilized by the faculty representing Clinical Oncology, McArdle Cancer Laboratory, the Therapeutic Radiology Center, and other Medical Center groups.

The orientation and experience from the course should be invaluable to physicians with starting or growing interest in controlling disseminated neoplasms, according to R. J. Samp, M.D., Cancer Program Coordinator, University Hospitals, Madison 53706.

Recent Advances in Pharmacology, Iowa

The American College of Physicians will present a course on "Clinical Applications—Recent Advances in Pharmacology" at the University of Iowa, Iowa City, June 19–21. Director is William B. Bean, M.D.

Purpose of the course is to review recent advances in pharmacology and to emphasize clinical applications of this new knowledge. The lectures and panel discussions will also stress current concepts in the treatment of the major disease processes encountered by the practicing physician.

Registration fees: ACP members, $60; nonmembers, $100. Registration requests to: Edward C. Rosenow, Jr., M.D., Executive Director, ACP, 4200 Pine Street, Philadelphia, Pa. 19104.

Annual Otolaryngologic Assembly, Chicago

The Annual Otolaryngologic Assembly of 1967 will be held October 14 through 20 in the new Illinois Eye and Ear Infirmary at the Medical Center, Chicago. The Department of Otolaryngology of the College of Medicine of the University of Illinois offers a condensed postgraduate basic and clinical program for practicing otolaryngologists under the direction of Dr. Emanuel M. Skolnik. It is designed to bring to specialists current information in medical and surgical otorhinolaryngology.

A separate, but correlated course entitled "Head and Neck Radiology Conference" will be conducted by the Department of Radiology for two full days just preceding the Assembly, Thursday and Friday, October 12 and 13.

Interested physicians should direct communications to the mailing address: Department of Otolaryngology, P. O. Box 6998, Chicago, Ill. 60680.

Counseling in Marriage Problems, Colorado

A postgraduate medical education course at the University of Colorado School of Medicine entitled "Counseling in Marriage Problems for Physicians and Clergy" will be held June 19–23 at the YMCA Conference Center, Estes Park, Colo.

Guest faculty: Mary S. Calderone, M.D., Executive Director, Sex Information and Education Council of the U. S. (SIECUS), New York City; Edward J. Hornick, Jr., M.D., Associate Professor of Psychiatry, Albert Einstein College of Medicine; Bronx, N. Y.; Richard H. Klemer, Ph.D., Associate Professor, University of Washington School of Medicine, Seattle, Wash.; Emily H. Mudd, M.S.W., Ph.D., Professor of Family Study in Psychiatry, University of Pennsylvania School of Medicine, Philadelphia, Pa.; and Dane G. Prugh, M.D., Professor of Pediatrics and Psychiatry, University of Colorado School of Medicine, Denver, Colo.

Local faculty includes members of the faculty of the University of Colorado School of Medicine, clergymen and professional persons from the Denver area.

Tuition for single registrant: $80; for physician–clergyman team: $120. Contact: The Office of Postgraduate Medical Education, University of Colorado School of Medicine, 4200 East Ninth Avenue, Denver, Colo. 80220.

Society for Cryo-Ophthalmology

The second annual meeting of the Society for Cryo-Ophthalmology will be held in Miami Beach, Fla., Jan. 14 to 18, 1968, with Dr. Jose Barraquer, of Bogota, Colombia, presiding. The program will include a session on retinal surgery, with Doctor Giambattista of Rome as the featured speaker. Dr. H. Fanta, of Vienna, will lead the discussion on cryoextraction of cataracts.

Those wishing to present papers at this meeting should submit title and brief abstract to Dr. John G. Bellows, executive secretary, 30 N. Michigan Ave., Chicago, Ill., 60602, at the earliest possible date.

Internal Medicine: Cincinnati

The American College of Physicians will present a postgraduate course on "Internal Medicine: Current Physiological Concepts in Diagnosis and Treatment" at the University of Cincinnati College of Medicine, June 12–16. Director of the course is Richard W. Vilter, M.D., F.A.C.P.

The aim of this course is to provide discussion of various aspects of internal medicine. Particular emphasis will be placed on cell biology, genetics, physiology, and recent advances made through the application of physical and chemical methods. The

impact of clinical pharmacology will also be emphasized. In general, the program will consist of morning lectures, and on three days a period of ward rounds in smaller groups. In the afternoon there will be lectures followed by conferences in which discussion will be encouraged. Diagnosis and treatment will be stressed. The subject matter as a whole has been arranged for the busy physician who has a desire to understand the basic mechanism of disease and its management.

Tuition fees: members, $60, nonmembers, $100. Registration forms and requests for information are to be directed to Edward C. Rosenow, Jr., M.D., F.A.C.P., Executive Director, American College of Physicians, 4200 Pine Street, Philadelphia, Pa. 19104.

Tri-State Annual Meeting, Blood Banks

The Fifth Annual Tri-State meeting of the Wisconsin–Illinois–Iowa Associations of Blood Banks will be held at the Sherman House, Chicago, Ill., May 26–28.

The Program Committee has been successful in obtaining excellent speakers who are considered authorities in their subject. The Program and Planning Committees of the Wisconsin–Illinois–Iowa Associations of Blood Banks have noted an increase in attendance each year. This would indicate that technical, medical and administrative personnel engaged in blood banking and transfusion therapy are desirous of knowing of the progress being made especially in the preparation and use of blood components.

Wisconsin physicians participating in the program include Drs. Gordon E. Lang of Milwaukee, R. D. Sautter of Marshfield; and Ruth Dalton of La Crosse. R. F. Ambelang, president of the Wisconsin Association of Blood Banks, also will be on the program.

Seminar, Diseases Common to Animals and Man

The Annual Midwest Interprofessional Seminar on Diseases Common to Animals and Man will be held October 4–5 at the University of Missouri, Columbia. Further details from Dr. Donald C. Blenden, Department of Veterinary Microbiology, Section of Public Health, School of Veterinary Medicine, University of Missouri, Columbia, Mo. 65201.

American Association of Blood Banks

The 20th Anniversary Meeting of the American Association of Blood Banks will be held October 21–25 at the Americana Hotel, New York City. Further details from, Central Office Manager, Miss Lois J. James, Suite 1322, 30 N. Michigan Ave., Chicago, Ill. 60602.

Abstracts for papers to be read during the Scientific and Administrative Sections are being accepted through June 1, 1967. Forms for submitting the abstracts may be obtained from the Central Office, Suite 1322, 30 N. Michigan Ave., Chicago, Ill. 60602.

Medical–Legal–Industrial Symposium

Mount Sinai Hospital, Milwaukee, will conduct a symposium for doctors, lawyers, and industrialists on Friday, November 17, in the Grand Ballroom of the Pfister Hotel in Milwaukee. The program, entitled "Pulmonary Diseases in Industry," will be held from 8:45 am to 4:00 pm. Further details from, David Ansfield, MD, Chief-of-staff, Mount Sinai Hospital, 948 N. 12th St., Milwaukee 53233; Tel. (414) 271–2174.

AHA Meetings in 1967

Sept. 18–20: At Boston, "Congenital Heart Disease Problems," directed by Dr. Alexander S. Nadas, co-sponsored by Massachusetts Heart Association.

Nov. 30–Dec. 3: "Electrocardiographic Diagnosis of Arrhythmias," directed by Dr. Henry J. L. Marriott, co-sponsored by Florida Heart Association at St. Petersburg, Florida.

Further information for the three-day courses may be obtained from the Director of Medical Education, American Heart Assoc., 44 E. 23rd St., New York, N.Y. 10010.

Nurse–Midwifery Convention, Milwaukee

The American College of Nurse–Midwifery will hold its annual convention at the Coach House—Holiday Inn Central, Milwaukee, June 8–10. Principal speaker for the opening session at 2 p.m. Thursday, June 8, will be Mrs. Katherine Oettinger, Chief, Children's Bureau, United States Department of Health, Education and Welfare. Her topic is entitled "The Health of Mothers and Babies."

Dr. J. Edward Hall will be moderator for the Friday afternoon panel on "The Nurse–Midwife As a Practitioner on the Obstetrical Team."

General Practice Review, Colorado

A postgraduate medical education program of the University of Colorado School of Medicine will be held July 16–22 at Denver on "General Practice Review." Subjects include: Cardiology and Cardiovascular Surgery, Medicine, Pediatrics, Surgery, Trauma, Obstetrics and Gynecology, and Dermatology.

Inquiries to: Office of Postgraduate Medical Education, U of C School of Medicine, 4200 East Ninth Avenue, Denver, Colo. 80220.

Medical Motion Pictures, Color TV To Again Be Features at AMA Annual Convention

Medical motion pictures and color television will be a feature of the Annual Convention of the American Medical Association again this year.

The Convention is to be held in Atlantic City, June 18–22, the Scientific Program at Convention Hall and nearby hotels and the House of Delegates at the Chalfonte–Haddon Hall Hotel.

MEDICAL MEETINGS *continued*

Medical motion pictures have become an integral part of the Annual Convention program. Movies are carefully screened and selected for quality, content and diversity of subject matter. Some are chosen from the AMA library of medical motion pictures while others are picked from among films just completed. Several new films are usually shown for the first time at the Annual Convention. The total movie program is thus planned to achieve both variety and currency.

Medical motion pictures will be presented daily. At least five color television programs will be presented live, on a closed circuit from a Philadelphia hospital in cooperation with the University of Pennsylvania School of Medicine.

Several of the Scientific Sections will participate in this year's color television program.

The entire Scientific Program for the 1967 Annual Convention was published in the May 8 issue of the *Journal of the American Medical Association.*

AHA Arteriosclerosis Council Meeting

The 1967 annual meeting of the American Heart Association's Council on Arteriosclerosis is scheduled for Wednesday and Thursday, October 18–19, in San Francisco, immediately preceding the Association's annual three-day Scientific Sessions program.

Abstracts of papers for presentation at the separate two-day Council meeting must be received before May 15. Forms for submitting abstracts may be obtained from Dr. Alfred M. Bennett at the Heart Association's National Office, 44 East 23rd St., New York, N.Y. 10010. The Council sessions will be held at the Town House.

Wisconsin Medical Assistants Annual Meeting

"Winning Ways for Working Days" will be the theme of the twelfth annual meeting of the Wisconsin State Medical Assistants Society, June 9–10 at the Park Motor Inn in Madison.

A pre-convention executive board meeting will be held from 9:00–11:30 AM Friday, June 9, followed by a luncheon for the board, advisors, and delegates, courtesy of Wisconsin Physicians Service. The House of Delegates will meet at 1:30 PM with Speaker Alice Budny presiding. A welcome party will be held in the evening from 8:00–10:00.

On Saturday, June 10, the general session will commence at 9:00 AM with President Vera Erdman presiding. Sister Mary Theophane, SSND, of the Notre Dame Infirmary, Elm Grove, will speak on the subject "A People Person." She will be followed by Attorneys Ted Bleckwenn and Forrest Brimmer of Madison, who will discuss "Protecting the Doubtful Dollars for Your Doctor."

A president's luncheon will be held from noon to 1:30 during which there will be presentation of membership award and recognition of past state president and county presidents. Mrs. W. Lee Hammer of Marquette University, Milwaukee, will conduct a workshop on "Getting to Know You" from 2:00–4:00.

A social hour will precede the banquet which will start at 7:30. Guest speaker will be Mary Duffy McBride, top writer for comedian Phyllis Diller. Her topic will be "A Funny Thing Happened." There will be installation of officers and an acceptance speech by the incoming president.

On Sunday, June 11, there will be a brunch presided over by the state president. A summary of the proceedings of the House of Delegates will be presented and announcement made of the 1967–1968 standing and special committees.

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Society Hosts a Health Careers Day

Over 100 high school students from Eau Claire, West Bend, Sheboygan, Sheboygan Falls, Beloit, Oshkosh, and Viroqua visited the State Medical Society headquarters and Madison hospitals April 15 during the Society's Health Careers Day.

Purpose of the gathering was to learn of career opportunities in health fields and the educational requirements in achieving them.

Groups toured Madison hospitals in the morning, then met at the Society headquarters for lunch and an afternoon program of speakers. Addressing the students were representatives of medicine, nursing, hospital administration, medical and dental technology, and education.

Participating in the program were Mrs. Virginia Cascio of the State Vocational, Technical and Adult school system; Betty M. Johnson, R.N. of the School of Nursing, University of Wisconsin; Alice Schmitt, R.N., director of nursing education of Madison General Hospital; E. J. Connors, superintendent, University Hospitals; and Mrs. Karyl Andreoli, R.N., public health nurse of the Madison health department.

This is the third such program offered by the Society for Wisconsin high school juniors and seniors.

A HEALTH CAREER subject is discussed by a staff member, Mrs. Jean Anderson, right, during a tour of the Society headquarters.

A SNACK BREAK during the course of the Health Careers Day was delightfully received as a staff member, Marguerite Cardts, right, serves.

Woman's Auxiliary Takes Part in Legislative Day

Members of the Woman's Auxiliary to the State Medical Society studied legislative proceedings at a Legislative Day in Madison April 18. The group attended committee hearings and visited the Assembly and Senate where they were introduced by their respective legislators. Gathering in the corridor of the State Capital for the day's activities are, left to right: Mmes. G. W. Chesemore and B. I. Brindley of Madison; J. W. Sargent of Milwaukee; K. W. Cavell, W. C. Miller, Vernon Burch, and K. C. Kehl of Racine; and M. M. Smith and R. C. Wixson of Madison. Mrs. Chesemore is executive secretary of the Auxiliary. The group met at State Medical Society headquarters before touring the Capitol. At a noon luncheon at the Madison Club, the group heard Pharis Horton, a Society counselor, explain his duties as a lobbyist, and H. B. Maraney, Society staff member, discuss legislation in general.

UW Preceptors and Medical Faculty Meet

Some 30 preceptors to the University of Wisconsin Medical School met at State Medical Society headquarters in Madison April 12 for their semi-annual gathering. They were joined at dinner by about 15 members of the medical faculty. *Dr. Thomas Meyer*, assistant dean of the Medical School, was in charge of the meeting. *Dean Peter L. Eichman* was present and briefly addressed the group. Discussion centered around a review of the preceptorship program.

PRECEPTORS: *Drs. Ben R. Lawtan, Marshfield; Peter A. Midelfart, Eau Claire; Warner S. Bump, Rhinelander; and Guy G. Giffin, Eau Claire.*

Wisconsin's preceptorship program, begun in 1925, was the first to be started by the modern group of medical colleges. Preceptors extend their services and guidance to the senior medical students without remuneration.

PRECEPTORS: *Drs. Eugene E. Eckstam, Monroe; Thomas G. Olsen, Marshfield; and Thomas J. Rice, Marshfield.*

MEETINGS AND SPECIAL EVENTS HELD AT THE STATE MEDICAL SOCIETY "HOME" DURING THE MONTH OF APRIL 1967

4 Board of Trustees, Dane County Medical Society
4 Surgical Staff, Madison General Hospital
4 Madison Urological Society
4 Madison Anesthesiology Society
5 Advisory Committee to State Alcoholism Service
5 Symposium on Geriatric Patient (Eau Claire)
6 State Board of Health (Madison)
8 Executive Committee, Council
8 Commission on Public Relations and Communications
10 Annual Meeting, Wisconsin Health Council
12 University of Wisconsin Medical School Preceptors and Faculty
12 Marshall High School Student Tour
15 Health Careers Program
16 Third Councilor District Caucus
18 Legislative Day, Woman's Auxiliary to SMS
19 Editorial Board, WISCONSIN MEDICAL JOURNAL
19 Planning Committee, Wisconsin Regional Medical Program
24 Insurance Advisory Committee, Dane County Medical Society
25 Subcommittee, Division on Visual and Hearing Defects
26 Reception, Dane County Unit, Wisconsin Heart Association
27 Photography Contest Judging
27 Division on Aging

Meetings not held in the Society "Home" but have a direct relationship are printed in italics, with the location in parentheses.

Symposium on "The Geriatric Patient: Profile of the Aged"

An estimated 250 physicians and representatives of related medical professions attended a symposium at the Eau Claire Country Club April 5 dealing with the geriatric patient.

Dr. Nolan Lewis, emeritus professor of psychiatry from Frederick, Md., was moderator. He noted the increasing concern of the medical profession with the problems and care for the aged.

Doctor Lewis, who is called one of America's "pioneers" in psychiatry, has had a long career as a professor, researcher, and writer on psychiatric subjects.

In introducing speakers and summarizing presentations, he enlivened the meeting with comments such as:

"In psychiatry we never get all the story; it's like reading a few installments of a serial story that's been going on before and keeps on going afterwards."

"There is no long life without good health that's worth anything."

"Some of the most normal brains I've ever seen (in autopsies) have been from senile individuals."

"The older persons still need love, and they often spoil their grandchildren because of their need for affection."

Case presentations were given by *Drs. Robert Lotz* and *Peter Midelfart*, Eau Claire; *Robert Leasum*, Osseo, and *James Maser*, Rice Lake.

Doctor Lotz reviewed the histories of several elderly patients who had developed into alcoholics after retirement, or after losing husband or wife. "Isolation" resulting from withdrawal from work or loss of family appeared to be a definite factor in the alcoholism, he said. "Very often it is found that alcohol is chosen by older people because of its ability to provide inner warmth, tranquility, and a sense of intimacy," he continued.

Medicolegal aspects were discussed by Jules Hannaford, chief legal counsel for the Minnesota State Medical Association. Dr. Jesse Barron, specialist in internal medicine at Minneapolis, discussed the geriatric patient and the physician.

The psychiatric implications of a physician's illness was presented by Dr. Edward Litin, head of the section of psychiatry at the Mayo Clinic, Rochester, Minn.

He said that a seven-year study of 6,000 patients treated in his unit showed a "highly disproportionate ratio" of physicians. A total of 93, ranging in age from 28 to 86 years, was treated during that period, he said, with 47 of them tracing their difficulties to alcohol or the use of narcotics.

Dr. Francis Forster, chairman of the department of neurology at the University of Wisconsin hospitals discussed the neurological problems of aged.

The physician-patient relationship in geriatric treatment was presented by Dr. James Elmore, instructor in psychiatry and fellow in geropsychiatry, Duke University, Durham, N. C. The socio-economic problems facing the patient and physician were presented by Vivian Wood, Ph.D., assistant professor of social work at the University of Wisconsin.

As final speaker of the program, Doctor Wood discussed the misconceptions relating to the elderly: "The general stereotype of older people in this country is that they are poor, sick, lonely, and isolated. Some are, but most are not," she said. "It is because the poor, the sick, and the lonely are most apt to come to public attention that this image of the aged has been created."

The program, approved for five hours of credit by the American Academy of General Practice, was sponsored by the Society's CES Foundation, the Wisconsin Psychiatric Institute, Division of Mental Hygiene of the State Department of Public Welfare, Wisconsin Academy of General Practice, a number of pharmaceutical companies, and the Northwest Psychiatric Clinic of Eau Claire.

WISCONSIN'S HEALTH by E. H. JORRIS, M.D., State Health Officer

WISCONSIN HOSPITAL DEVELOPMENT CONTINUES

Early in April the State Board of Health announced that about $5.5 million in federal grants is available to Wisconsin for the construction and modernization of hospitals and medical facilities. An assignment of priorities was made. When this current allocation is committed to specific projects the total amount of federal aid for hospitals in Wisconsin will reach a total of $63,368,236. So far, every dollar of federal aid money allocated to hospitals and medical facilities in this state has been utilized.

Anyone who has a copy of the official Wisconsin state highway map can quickly determine where there are hospitals that can render emergency care. Communities in which these hospitals exist are marked in the city and village index that appears on the back of the map. The 1967 edition indicates 119 communities with hospitals.

These 119 do not constitute a list of all hospitals in the state. Some cities have more than one hospital and other hospitals are specialized.

Recently the Division of Hospitals and Related Services of the State Board of Health released the current directory of general hospitals, mental hospitals, tuberculosis hospitals, and related institutions. The directory is available on request. It lists 240 institutions, of which 84 are classed as publicly owned and 156 are privately owned, usually by a non-profit organization. There are 174 general hospitals, 15 tuberculosis hospitals and 51 mental hospitals.

In the first section of the directory the hospitals are listed alphabetically by city. Included is the name, street address and telephone number of the hospital, an enumeration of the type of hospital, ownership and bed capacities, and the names of the president of the hospital board, the administrator, the chief of staff, and the director of nursing service.

The second section of the directory lists hospitals by county. It identifies the institutions by name, type of service and ownership. Bed capacities in the various categories are given and county totals are provided.

Only four counties, Florence, Iron, Marquette, and Menominee, have no hospitals within their boundaries. The presence or absence of a hospital within a government unit is of relatively minor importance. What matters is whether hospital service is available within practicable time and travel limits. One of the goals of federal aid to hospitals was to assure this service by a law passed in 1946 which delegated to the State Board of Health the responsibility to prepare a state plan for the development and modernization of hospitals. With the assistance of the 20-member state hospital advisory council the plan is reviewed and revised each year. As a result of this planning over two decades, virtually every resident of Wisconsin is within a half hour travel time to care in a general hospital.

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NEWS OF WISCONSIN PHYSICIANS

Dr. Schulz Joins Beaver Dam Group

Dr. Norman H. Schulz, Horicon physician, has joined the staff of the Beaver Dam Medical Associates. He received his MD degree from the University of Wisconsin in 1953 and interned at the County Hospital in Sacramento, Calif. Doctor Schulz was a general practitioner in Horicon for eight years before joining the Medical Associates staff.

Dr. Kettelkamp Renamed to Board

B. H. Kettelkamp, Ph.D., River Falls, was recently named by Governor Knowles to a third six-year term on the state board of examiners in the basic sciences.

Dr. Whalen Honored on His Day

Dr. Maurice L. Whalen, Bruce, was honored recently at a "Doc's Day" dinner held at the Bruce school. More than 250 people attended in honor of his 35 years of devoted service to the community. Doctor Whalen was born in Minnesota, Aug, 31, 1906, and graduated from the University of Minnesota in 1929 and spent one year of internship at St. Luke's Hospital in Duluth. He practiced in Duluth for two years before coming to Bruce on Feb. 1, 1932. Doctor Whalen also serves as chief surgeon at St. Mary's Hospital in Ladysmith.

Dr. M. L. Whalen

Doctor Whalen has been instrumental in preserving medical history through his contributions to the Museum of Medical Progress in Prairie du Chien, an activity of the State Medical Society's CES Foundation. (Photo courtesy LADYSMITH NEWS)

Dr. Curreri Guest Speaker

Dr. Anthony Curreri, director of Clinical Oncology and professor of surgery at the University of Wisconsin Medical Society, recently spoke on his impressions of Vietnam, telling what he saw on his inspection tour of that country to a group of 200 people at the First Congregational Church, Madison.

Dr. Jacobi Guest Speaker

Dr. Michael A. Jacobi, radiologist at Holy Family Hospital, Manitowoc, was the guest speaker recently at the Christian Mothers Altar Society, in Two Rivers. He discussed modern treatment of malignant growths and tumors and demonstrated the use of closed-circuit television and video tapes.

UW Medical Library Named for Dr. Middleton

Phase I of the Medical School Library recently was named in honor of *Dr. William S. Middleton,* emeritus professor of medicine. Doctor Middleton retired in 1955 after 43 years of service to the Medical School, including 20 years as dean. From 1955 to 1963 he served as chief medical director of the Veterans Administration.

Dr. Green Speaks Before Traffic Managers

Dr. Robert Green, La Crosse, spoke on "Better Odds for a Longer Life" before traffic managers in the Northern States Power Co. office in La Crosse.

Dr. Galang Joins Algoma Clinic

Dr. Luis Galang recently became associated with the Algoma Clinic. Doctor Galang received his medical education in Manila. He was a staff physician at St. Mary's Hill Hospital, Milwaukee, two years before moving to Watertown where he was engaged in general practice. Doctor Galang will specialize in surgery at the Algoma Clinic.

Dr. Kauffman Joins Marquette University

Dr. H. Myron Kauffman, Lexington, Ky., will join the department of surgery at the Marquette University School of Medicine in July to head a new kidney transplant team at county general hospital. Doctor Kauffman is an assistant professor of surgery at the University of Kentucky Medical School and received his surgical training at the University of Virginia Medical School, where he gained kidney transplantation experience with Dr. David Hume, one of the developers of organ transplantation in the United States.

Dr. Lanier Guest Speaker

Dr. Patricia Lanier, Kewaunee, was the guest speaker at the Women's Club of De Pere in March. Her topic was "Retirement—What Does It Mean?" Doctor Lanier taught school several years before obtaining her MD at Washington University and becoming a fellow in internal medicine at Stanford University.

Dr. Troup Spends Month in Haiti

Dr. Wilson Troup, De Pere, recently spent a month in Haiti, where he performed eye surgeries and treated eye diseases in a hospital in remote southern Haiti. In 1965, Doctor Troup spent a similar period in northern Haiti providing eye care under "Focus," a medical project designed to provide eye care to depressed areas of Haiti with the help of American physicians. Focus was founded by a Chicago eye specialist, Dr. James E. McDonald.

Physicians whose names appear in italics are members of the State Medical Society.

Two Doctors Receive Cancer Grants

Dr. Louis Bernhardt and Dr. Robert Skor, Madison, have been awarded clinical fellowships by the American Cancer Society. The announcement was made by *Dr. Gerard I. Uhrich*, La Crosse, president of the Wisconsin Division of the ACS.

Doctors in Press Conference on Smoking

Dr. William Chandler, Appleton, recently discussed the Effects of Smoking on Your Lungs before a group of teenagers from seven area high schools in Appleton, Kimberly, and Little Chute. The conference was sponsored by the education committee of the Outagamie Unit, American Cancer Society. *Dr. Pearce Meighan* and *Dr. Ralph Kennedy* also participated in the conference.

UW Starts Sports Medicine Course for Physicians

The University of Wisconsin Medical School this fall will offer the first full-time course in sports medicine for physicians in the United States. The course, to be conducted as part of the Medical School's program of continuing education, is open to a limited number of interested physicians. It will begin September 1 and continue through May 1 of next year.

According to *Dr. Allan J. Ryan*, physician for University of Wisconsin athletic teams and director of the new course, there is a growing need in U. S. college and university athletics for physicians who can dedicate themselves full-time to sports medicine.

"The care of athletes, particularly in larger schools, should be a full-time proposition, and sports medicine recognized as a legitimate specialty," Doctor Ryan said. He pointed to Wisconsin's athletic program, with 750–800 varsity and freshman athletes each year, as evidence of the difficulty of a part-time medical service. "Student health services or physicians on part-time contracts should not be expected to bear this burden," Doctor Ryan said.

The sports medicine course will be open to a maximum of eight physicians, and will not offer a degree, though a certificate of proficiency will be awarded. The course, Doctor Ryan explained, will be divided about equally between classroom and laboratory work and clinical practice.

Faculty members will be drawn from the Medical School's department of surgery, and from the University's departments of physical education and athletics. The course has been organized so that physicians can participate on a half-time basis, Doctor Ryan said.

"We hope that full-time students will be able to engage in research while they are here," Doctor Ryan said. "Sports medicine is a mostly untapped research area." Half-time students may be employed as staff members of the health service on a part-time basis.

"We intend this course to be the first step in opening up a new area of medical practice in this country," Doctor Ryan said. "We are anticipating a healthy response from the medical profession."

Dr. Gingrass Joins Marquette Faculty

Dr. Ruedi P. Gingrass has joined the Marquette University medical faculty as a full-time assistant professor of plastic and reconstructive surgery at county general hospital. He is the son of *Dr. Rudolph P. Gingrass*, clinical professor of oral and maxillofacial surgery at Marquette dental school, and of plastic and reconstructive surgery in the medical school.

Dr. Brennan Honored

Dr. John J. Brennan, Wauwatosa, was presented the "Irishman of the Year" award recently at a dinner-dance of the Shamrock Club of Wisconsin. Doctor Brennan is on the faculty of the Marquette University School of Medicine.

Dr. Giffin Guest Speaker

Dr. W. S. Giffin, Appleton, recently was the guest speaker before a group of Holy Cross Home School members and guests in Kaukauna. He spoke on sex education and emphasized that it is the parents responsibility to teaching their children the facts of life.

Dr. Roberts on Health, Sex Education Panel

Dr. Richard W. Roberts, Oshkosh, recently spoke on "Understanding Your Body and How and Why You Grow" before the father–son sex education and health classes held in Oshkosh.

Dr. Bates Talks to Altar Sodality

Dr. Donald Bates of Fort Atkinson recently spoke before a group of women, including a number of sisters from St. Coletta, Jefferson, on the "pill" at the Altar Sodality meeting in St. Joseph's Catholic Church parish hall in Fort Atkinson.

Dr. Falk Guest Speaker

Dr. Victor Falk, Edgerton, was the guest speaker at the American Legion birthday dinner and party held recently at Footville.

Dr. McMaster to Serve on Council

Dr. John McMaster, director of the University of Wisconsin Health Service, has been named to fill the remaining two years of the unexpired council term of Dr. Maurice M. Osborne, Jr. Doctor Osborne was recently installed as president-elect of the American College Health Association.

Dr. Myers Speaks at Auxiliary Meeting

Dr. Robert E. Myers, Two Rivers, recently spoke on "Cancer in the Female" at the meeting of Two Rivers Hospital Auxiliary.

Sinus headache is not a single entity, but a chain reaction of pain. It is facial pain—deep, dull, aching and nonpulsating. It is referred pain—originating in the nose and sinuses but felt at another site. It may become generalized pain and tension in head and neck. It is one or all of these.

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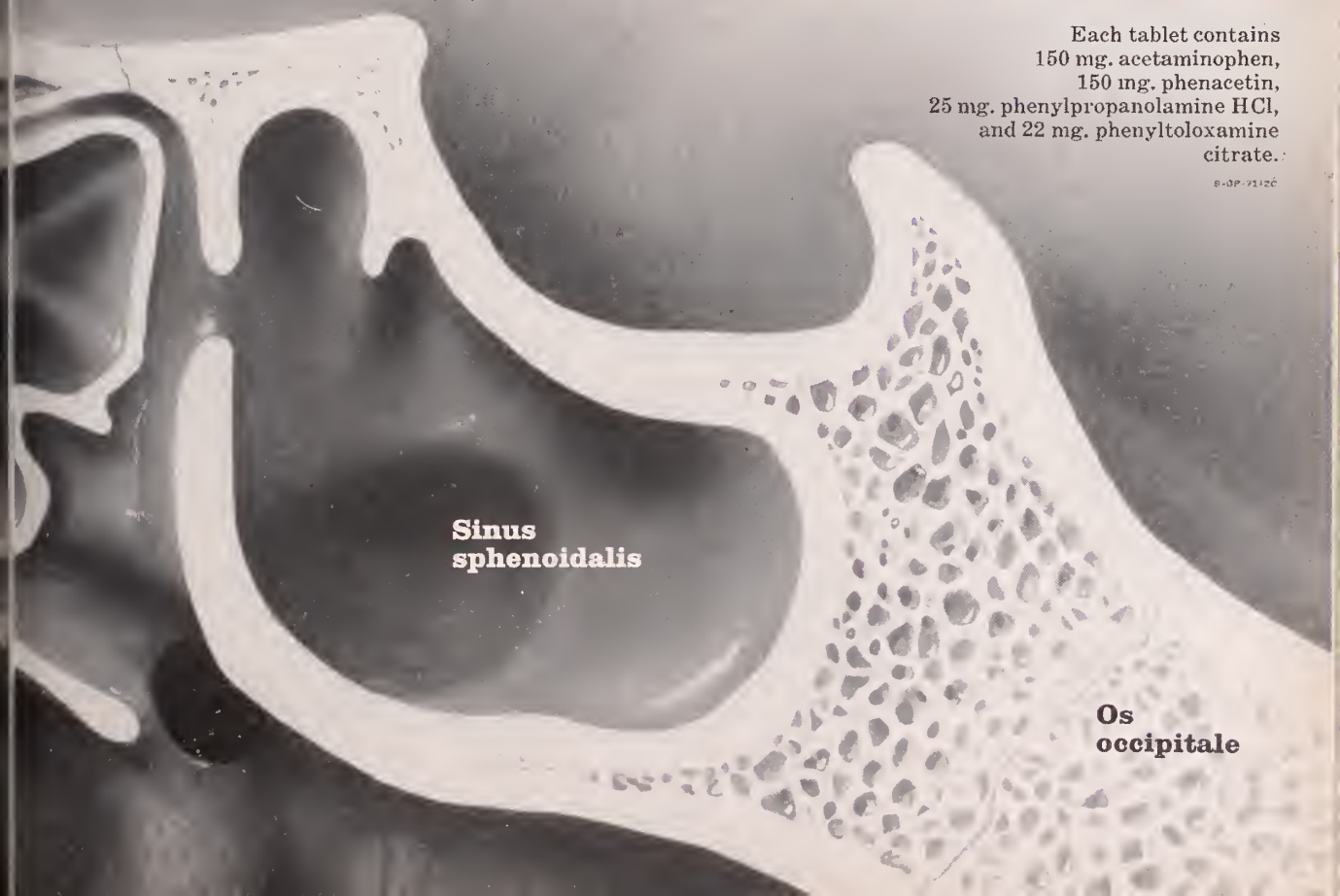

Dr. Carroll Takes Course at Harvard

Dr. Paul E. Carroll, Waukesha, recently took some courses at the Boston Hospital for Women, Lying-in Division, under the auspices of Courses for Graduates, Harvard Medical School, for an intensive postdoctoral study in female medicine.

Dr. Vogel Discussion Leader

Dr. Thorn L. Vogel, Janesville city health commissioner, recently was the discussion leader for a series of lectures on health and sex education at Milton for fathers and sons.

Dr. King Honored by Marquette Graduates

Dr. Joseph M. King, Wauwatosa, retired director of surgery at Milwaukee County General Hospital, has been named the Marquette University Alumnus of the Year, according to Ralph E. Lassa, D.D.S., president of the Marquette Alumni Association.

Dr. J. M. King

Doctor King, a 1920 graduate of the Marquette University School of Medicine, retired as director in 1962 after more than 40 years of dedication to patient care and teaching.

It is estimated that more than 364 surgeons in Milwaukee and throughout the country were trained by Doctor King. He is presently serving on the tissue committee at St. Joseph's Hospital.

Doctor King was one of the original organizers of the Medical School Alumni in 1925.

Dr. Friesendorf Speaks to Golden Agers

Dr. Richard E. Friesendorf, assistant chief of cardiology for the Veterans Administration and also an instructor in internal medicine at Marquette University, recently spoke on "Making the Most of Maturity," to a group of Golden Agers at the Jewish Community Center in Milwaukee. Doctor Friesendorf urged the group to "forget stress and get out and move your muscles."

Dr. Richards Elected Chairman

Dr. John N. Richards, Kenosha, was elected-chairman of the Community Day Care Services Board of the Kenosha Achievement Center, at a recent meeting held by the group in Kenosha.

Doctors Speak to Policemen

Dr. Warren K. Simmons and *Dr. Marvin Wright* of the Bump Clinic in Rhinelander recently spoke at the police training program session. Doctor Simmons spoke on the effects of alcohol and Doctor Wright spoke and showed movies on emergency procedures for childbirth.

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Dr. Hellmuth Has Speaking Engagements

Dr. George A. Hellmuth, director of the Marquette University School of Medicine Cardiac Work Classification Unit, spoke to the President's Committee on Employment of the Handicapped" at the group's annual meeting April 27 in Washington, D. C. His topic was "Medical Criteria for Employment of the Cardiac."

He spoke on "Workmen's Compensation and the Cardiac" April 19 in Chicago at the Heart-In-Industry Conference sponsored by the Chicago Heart Association.

Doctor Hellmuth was guest of honor at the Roundtable Meeting of the Self-Insurers' Division of the Wisconsin Manufacturers Association March 16 in Milwaukee. He discussed "The Heart Case and Workmen's Compensation."

Dr. Keuer Heads Staff

Dr. James R. Keuer, Medford, recently was elected president of Memorial Hospital of Taylor County medical staff. He succeeds *Dr. Edward Regehr*, Athens. *Dr. Griffith Thomas*, Prentice, was elected vice-president and *Dr. W. W. Meyer*, Medford, was named secretary.

Doctor Bittle Transfers Membership

A former Wisconsin physician, Dr. Kenneth A. Bittle, has transferred his membership from the Winnebago County Medical Society to Ventura County Medical Society in California. Doctor Bittle moved in 1964 to Patton, Calif., where he became senior psychiatrist at Patton State Hospital in San Bernardino County. In the fall of 1966 he joined the staff of the Camarillo State Hospital at Santa Barbara.

Doctor Bittle is a 1947 graduate of Marquette University School of Medicine. He took his internship at St. Joseph Hospital, Milwaukee, following which he established a general practice in the Milwaukee area until 1957 when he began a residency in neuropsychiatry at Wood Veterans Administration Center. Upon completion of this training in 1960, he became staff psychiatrist at the Tomah VA Hospital. In 1962 he joined the staff of the Winnebago State Hospital.

There is a two-year waiting period for transfer of membership to California. Doctor Bittle has been a continuous member of the State Medical Society in various classifications since 1949.

Dr. Gordon to Preside at Seminar

Dr. Edgar S. Gordon, professor of medicine at the University of Wisconsin, Madison, was one of the educators to preside at the seventh annual Wisconsin Women's Day which was held in April on the Madison campus. Doctor Gordon's research has included the use of radioactive chemicals for treatment of cancer and toxic goiter, diets for the chronically overweight, and treatment of heart disease.

3 a.m.

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Dr. Youmans of UW Is Honored

An award of meritorious achievement, highest honor bestowed on a graduate of the University of Oregon Medical School, was given to William B. Youmans, Ph.D., April 7 by Medical School Alumni gathered for their 52nd Scientific Meeting at Portland.

In 1935 the doctor began studies for his Ph.D. degree at the University of Wisconsin in medical physiology. Shortly after that time he joined the staff of the Oregon Medical School as an instructor in physiology and in 1942 entered the School as a student. While he was taking medical classes, Doctor Youmans continued to serve on the faculty as an associate professor of physiology and between 1946 and 1952 was chairman of the department. In 1952 he returned to Wisconsin as professor and chairman of the department of physiology, a position he currently holds.

Dr. Stiehm Appointed Markle Scholar

Dr. E. Richard Stiehm, assistant professor of pediatrics at the University of Wisconsin Medical School, has received a five-year appointment as a Markle Scholar in Academic Medicine.

The scholarship, presented by the John and Mary R. Markle Foundation, is one of 25 similar awards made this year to U.S. medical schools. The award carries a $30,000 grant, which will be paid in $6,000 annual installments to the U.W. Medical School. The sum, according to the Foundation, will be used to "supplement salary, aid research or otherwise assist in the development" of the recipient. The grants have been made annually since 1948.

Doctor Stiehm, who received both the B.S. and M.D. degrees from the University of Wisconsin, joined the Medical School faculty in 1965. He took his pediatric residency at Babies Hospital, Columbia Presbyterian Medical Center, New York, and was a special fellow in pediatrics at the University of California Medical Center, San Francisco.

Doctor Stiehm received the medical degree in 1957 and was certified by the American Board of Pediatrics in 1964. His own research interests are in the areas of allergy, immunology and hematology.

Dr. Callan Appointed to Regional Program

Dr. Robert Callan of Milwaukee in April was appointed a permanent member of the Planning Committee of The Wisconsin Regional Medical Program, according to an announcement by *Dr. John S. Hirschboeck*, coordinator of the Program. Doctor Callan is speaker of the State Medical Society House of Delegates.

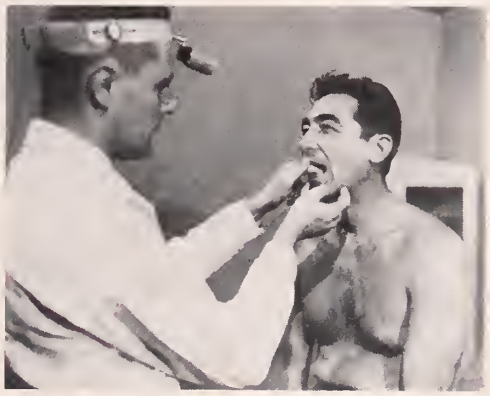
A NEW KIND OF DOCTOR PROPOSED BY DR. ROBERT F. SCHILLING

A new kind of doctor—trained in five years instead of nine—may be the answer to the continuing demand for general physicians in an age of specialization, a University of Wisconsin medical educator declared recently. The speaker, *Dr. Robert F. Schilling*, Madison, talked at the annual dinner meeting of the Wisconsin Medical Alumni Association at the University Club of Milwaukee, February 10.

He indicated he was talking personally, rather than as professor and chairman of the UW department of medicine. The new doctor idea, he said, was unrelated to sweeping changes that have been proposed in the UW medical school curriculum. The short-term medical practitioner, as Doctor Schilling conceived him, would be graduated five years after high school.

Doctor Schilling further stated that the new doctor might not have an MD degree. He would be trained primarily to provide routine care, such as immunization for children and prenatal care for pregnant women, and to refer more patients to an MD.

"ORAL CANCER" FILM



"ORAL CANCER", a 22-minute color film for physicians produced by the American Cancer Society, demonstrates a systematic five-minute visual and digital oral examination for cancer and urges all physicians to include this site in routine physical examinations. The film is part of the most comprehensive film program for professional audiences ever undertaken against a single disease. It shows in still and motion photography various oral lesions, and demonstrates several biopsy techniques. Follow-up examinations of several patients who have been treated for cancer demonstrate the favorable results which can be achieved by prompt, adequate therapy.

The film was financed by the Society's Texas Division and is available free for showing to medical audiences, through local Units of the American Cancer Society.

Dr. McRoberts Heads Surgery Group

Dr. Jerry McRoberts, Sheboygan, was elected president of the Wisconsin Section of the International College of Surgeons; *Dr. James Hoon*, Sheboygan, was elected secretary of the group.

Patient Paints Portrait of Dr. Young

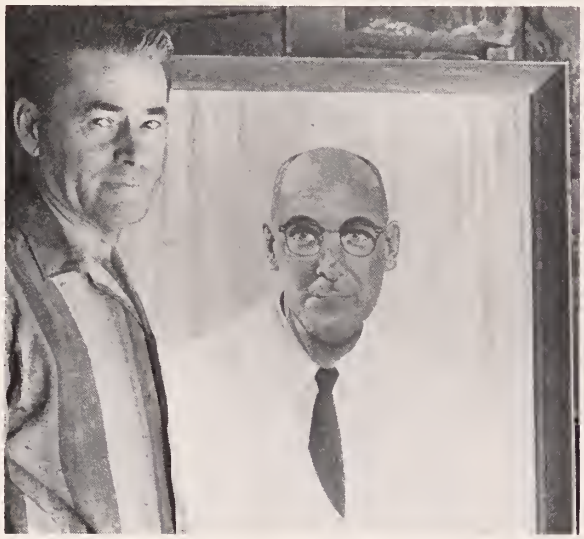


Photo courtesy Jim Frost, WISCONSIN RAPIDS TRIBUNE

To show his appreciation to the doctor who performed open heart surgery on him last July, Henry Morcotte of Wisconsin Rapids pointed a portrait of the doctor and presented it to him recently when he came for a routine checkup. A commercial artist, Mr. Morcotte painted the large oil portrait of *Dr. William P. Young* from a snapshot. The presentation was a complete surprise to Doctor Young who is a pioneer in the human heart valve transplant and has gained worldwide recognition for his work. Mr. Morcotte appears above with the portrait.

Dr. Soergel Attends Special Meeting on Colitis

Dr. Konrad H. Soergel, chief of gastroenterology at Marquette's medical school and at county general hospital, Milwaukee, recently attended a special meeting on ulcerative colitis in Milwaukee. Doctor Soergel pointed out that recent research findings about the cause of ulcerative colitis were "promising and exciting." The research was conducted at the Karolinska Institute in Sweden and confirmed by scientists at the Universities of Michigan and Chicago.

Dr. Lotz Reelected to Board of Education

Dr. Robert M. Lotz, Eau Claire, was reelected to his post as a member of the Board of Education. He is a graduate of the University of Wisconsin Medical School.

Dr. Davis Discusses Heart and Strokes

Dr. Nathan Davis, Manitowoc, discussed "Heart and Strokes" at the second meeting in a series of health discussions that was held at the Manitowoc Technical Institute recently.

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Warning: If coumarin-type anticoagulants are given simultaneously, watch for excessive increase in prothrombin time. Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea, sulfonamide-type agents and insulin. Carefully observe patients receiving such therapy. Use with great caution in the first trimester of pregnancy

Precautions: Obtain a detailed history and a complete physical and laboratory examination, including a blood count. The patient should be closely supervised and should be warned to report immediately fever, sore throat, or mouth lesions (symptoms of blood dyscrasia); sudden weight gain (water retention); skin reactions; black or tarry stools or other evidence of intestinal hemorrhage. Make regular blood counts. Discontinue the drug and institute countermeasures if the white count changes significantly, granulocytes decrease, or immature forms appear. Use greater care in the elderly and in hypertensives.

Adverse Reactions: The most common are nausea, edema and drug rash. The drug has been associated with peptic ulcer and may reactivate a latent peptic ulcer. Infrequently, agranulocytosis, or a generalized allergic reaction may occur and require withdrawal of medication. Stomatitis, salivary gland enlargement, vomiting, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported but cannot definitely be attributed to the drug Thrombocytopenic purpura and aplastic anemia may occur. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hyperglycemia, hepatitis, jaundice, and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently. Moderate lowering of the red cell count due to hemodilution may occur.

Dosage in Painful Shoulder: 600 mg. daily in divided doses for 2 to 3 days; 300 mg. daily thereafter. Usual duration of therapy: 2 to 7 days.

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COUNTY SOCIETY PROCEEDINGS

BROWN

For his pioneering efforts in the fields of mental health, George Kress, founder and chairman of the board of Green Bay Packaging, Inc., March 7 received the Brown County Medical Society's annual Medical Service Award. *Dr. Charles A. Wunsch*, retiring president of the Society, presented the award and gave the Society's annual report to the community at a luncheon at St. Vincent Hospital in Green Bay.

Photo by GREEN BAY PRESS–GAZETTE

GEORGE KRESS, left, receives the Medical Service Award from Dr. Charles Wunsch, retiring president of the Brown County Medical Society.

Physicians whose names appear in italics are members of the State Medical Society.

The citation noted Mr. Kress was instrumental in establishing the first branch of the American Foundation of Religion and Psychiatry in Green Bay in August of 1965, and numerous other activities including his work with the Wisconsin Heart Association.

Doctor Wunsch told of several Society accomplishments of the past year which he feels are important to the community. Much of the work was done by Society committees in cooperation with other community leaders, he said. Accomplishments and activities include: sponsorship of an Explorer Scout troop of young men interested in medical careers, standardized a fee schedule for physicians to use in services for welfare patients, considered the question of coroner and/or medical examiner, and studied utilization of hospitals following passage of the Medicare law.

CHIPPEWA

Dr. Paul G. Belau of Rochester, Minn., discussed "Office Ophthalmology for the Generalist" at the April 4 meeting of the Chippewa County Medical Society.

DANE

Members of the Dane County Medical Society met April 11 at the Hoffman House West in Madison. Guest speaker was Prof. Archie H. Easton who

IMMUNIZATION CLINICS, INCLUDING MEASLES, SLATED AROUND STATE

Many county medical societies around the state are conducting or sponsoring immunization clinics this spring. Clinics include immunization against whooping cough, diphtheria, tetanus, smallpox, polio, tuberculosis, and measles. While most of these diseases have had previous attention toward immunization, it is the measles innoculation which is demanding the attention of physicians, public health workers, and civic groups.

During the month of April, a statewide immunization program was carried out by the state Jaycees and the Wisconsin Association for Retarded Children, supported by the State Board of Health, the State Medical Society, and other groups. The month was declared as "End Measles" month. Many counties set up campaigns for measles immunization clinics during April and May. Also included with these clinics were immunizations against the other diseases listed above.

Counties in which the immunization clinics have been conducted or will be conducted this spring include: Ashland, Crawford, Douglas, Eau Claire, Jefferson, La Crosse, Lafayette, Marinette, Pierce, Price, Richland, Rock, Sauk, Shawano, Sheboygan, Vernon, and Walworth, and presumably others as they become known.

is an authority on the scientific investigation of automobile accidents, and this was the subject of his presentation.

New members of the Society are: *Dr. James T. Gascoigne,* associated with the East Madison Clinic; *Dr. Paul A. McLeod,* associated with the Jackson Clinic in Madison and a clinical instructor at University Hospitals; *Dr. Edward H. Olsen,* serving a residency in psychiatry at the University of Wisconsin; *Dr. Philip P. Rank,* an instructor at the University of Wisconsin Medical School, consultant to the VA Hospital, and associated with the University Radiology Associates; and *Dr. Charles William Young,* associated with the University of Wisconsin Department of Physiology.

A Doctor and His County Society Urge Increased Nursing Care

The need for additional facilities for the aged in Merrill and Tomahawk recently prompted a letter from *Dr. E. O. Ravn, Jr.* on behalf of the Lincoln County Medical Society explaining the purpose of the nursing care program which was approved by the Lincoln County Board. The letter appeared in the MERRILL DAILY HERALD and is excerpted below.

"The Lincoln County Medical Society strongly urges high priority of attention and planning for early completion of expansion of nursing home facilities in Lincoln County. . . . hospitals have been completely filled many times in the past months making it impossible to admit the acutely ill patient promptly or forcing a delay in admission of surgical patients. . . . Too high a percentage of hospital beds for the acutely ill are being occupied with older people awaiting nursing home disposition. . . . Some patients have been in the hospital for months and having exhausted all Medicare benefits and personal savings have been forced to seek county financial aid.

The Health Committee has recognized this problem . . . and approved of a measure that will help somewhat to ease the pressure on both hospitals and nursing homes. . . . The Nursing Service of Lincoln County is willing to undertake a home nursing care program that has been promoted and urged by the federal and state governments. . . . By means of this home nursing service, our patients will receive nursing attention at our direction in their own homes or homes of relatives. . . . The Lincoln County Medical Society is in complete favor of this Home Nursing Care program. We recognize the great help it will be in our present nursing home facilities shortage. . . . We emphasize, however, that the critical need, in spite of this measure, is additional nursing home beds that are needed now. . . . The doctors of Lincoln County appeal to the Board of Supervisors to give their wholehearted efforts to accomplish the needed expansion of nursing home facilities in Lincoln County. —E. O. RAVN, JR., M.D., Medical Advisor to the Health Committee of the Lincoln County Board of Supervisors.

DODGE

Twenty-three members of the Dodge County Medical Society met March 30 in Beaver Dam. *Dr. Theodore Rowan,* a pathologist in Beaver Dam, spoke on the history and development of education in England dating from the middle ages. He discussed certain educational differences found in schools in England and schools in the United States. He also commented about the medical education currently offered in England.

KENOSHA

Dr. Walter Rattan, president of the Kenosha County Medical Society, March 20 presented two medical society awards to students of St. Joseph High School at the annual science fair. Winners were Laurel Derks and Chuck Labanowsky.

LA CROSSE

Dr. and Mrs. *Alf Borge,* West Salem, discussed their medical work in Madagascar at a joint meeting of the La Crosse County Medical Society and its Auxiliary March 20 in St. Francis Hospital, La Crosse. Guests were Mrs. David Hammes, Green Bay, president of the Auxiliary to the State Medical Society of Wisconsin, and Mrs. Donald Britton, state vice-president.

MARATHON

The "does and don't" of ambulance service were pointed out March 27 to about 110 members and guests of the Marathon County Medical Society at the Holiday Inn, Wausau. Dr. J. D. Farrington, chairman of the transportation committee for the section on trauma of the American College of Surgeons, showed slides of the proper and improper treatment of ambulance passengers. He discussed various types of calls ambulance personnel may receive.

Doctor Farrington, a retired Chicago orthopedic surgeon, now lives in Minocqua, and does extensive traveling on speaking tours on the subject of the handling of injured persons. Firemen from Wausau and surrounding communities and members of the ski patrol were guests at the meeting.

OUTAGAMIE

Members of the Outagamie County Medical Society March 16 heard Earl Thayer, secretary of PACE—Professional Association for Civic Education, discuss the Association's aims and purposes.

COUNTY SOCIETIES *continued*

SHEBOYGAN

A joint meeting of the Sheboygan County Medical Society and its Auxiliary was held March 30 at the Pine Hills Country Club in Sheboygan. The 40 members in attendance heard Miss Ann Strelick, C.R.N.A., of Sheboygan, tell of her "Vacation in Nigeria." She showed slides and talked on her experiences while working at a hospital in Nigeria.

WALWORTH

Dr. Edward Klink of Rockford, Ill., discussed "Infertility Problems: General Practice Approach" at the March 16 meeting of the Walworth County Medical Society held at Lakelawn Lodge in Delavan. During the business session, there was discussion on whether out-of-county paramedical groups were working in the county without physician supervision.

WOOD

The Wood County Medical Society met March 30 at the Casa Loma in Marshfield. *Dr. T. F. Nikolai* of Marshfield discussed "Clinical Problems in Inheritance of Thyroxin-binding Globulin."

Following a discussion of legislation related to visual examinations to obtain a hunting license, led by *Drs. R. M. Heywood* and *J. A. Kunkel*, the Society voted to oppose this legislation.

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1. Crunden, A. B., Jr., and Davis, W. A.: Am. J. Obst. & Gynec. *65*:311 (Feb.) 1953.

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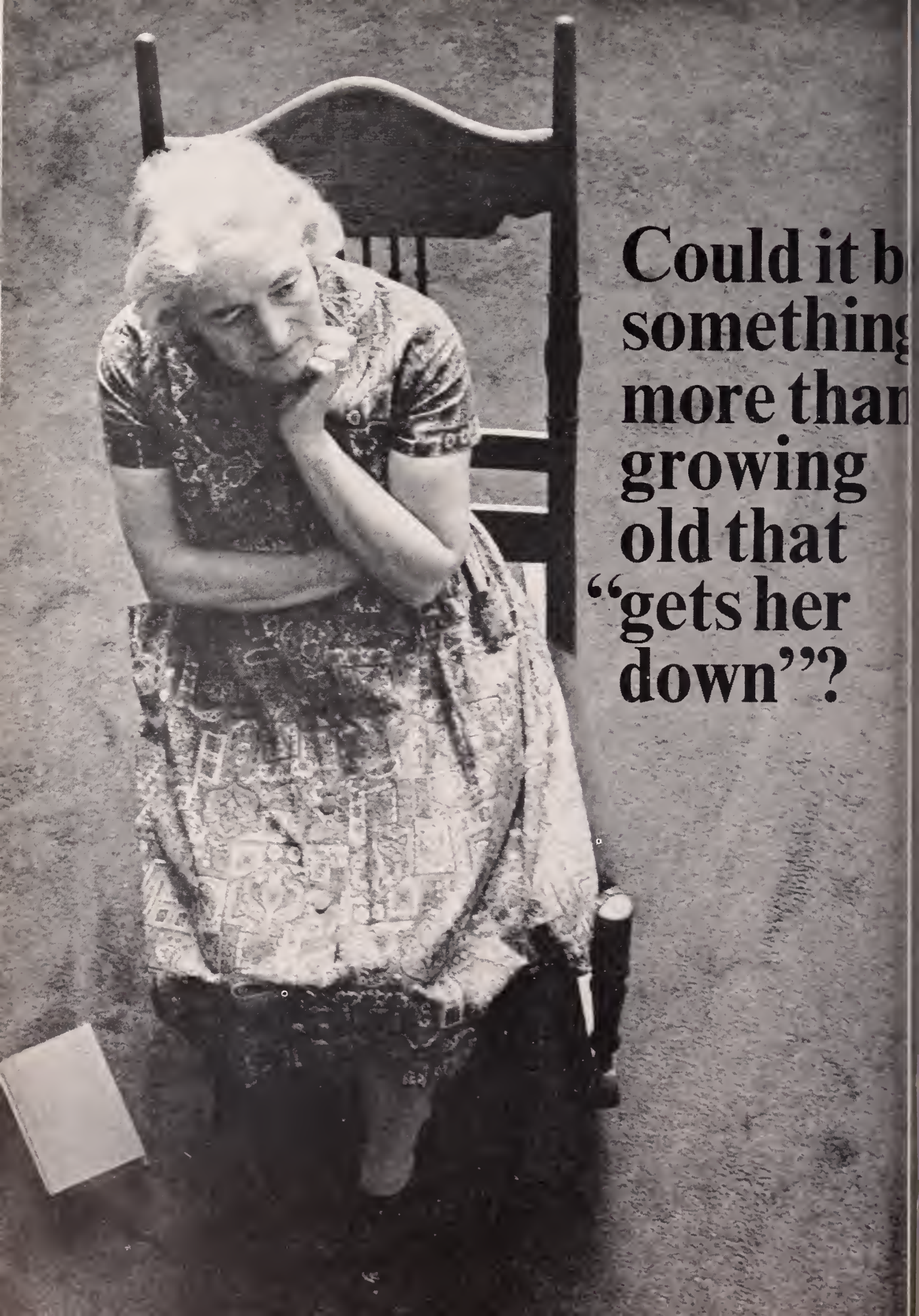
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*Multiple of adult Minimum Daily Requirement supplied.
†The need for these substances in human nutrition has not been established.

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Side effects: Reports of overstimulation have been rare. Patients who are known to be unduly sensitive to the effects of stimulant drugs should be observed carefully in the initial stages of treatment.

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SPECIALTY SOCIETY PROCEEDINGS

Milwaukee Academy of Medicine

The 934th meeting of the Milwaukee Academy of Medicine was held April 18 at the University Club of Milwaukee. Dr. David P. Boyd, chairman of the Department of Thoracic Surgery, Lahey Clinic Foundation, discussed "Carcinoma of the Thyroid."

Wisconsin Society of Anesthesiologists

The 1967 Ralph M. Waters Lecture, sponsored by the Wisconsin Society of Anesthesiologists, was presented by Dr. Perry P. Volpitto, past president of the American Society of Anesthesiologists and chairman of the department of anesthesiology of the Medical College of Georgia, April 24 at the University of Wisconsin Medical School. His topic was "Myocardial Infarction as a Sequela of Anesthesia and Surgery."

Physicians whose names appear in italics are members of the State Medical Society.

Milwaukee Ophthalmological Society

The April 12 meeting of the Milwaukee Ophthalmological Society was held at the University Club of Milwaukee. Dr. G. Von Noorden spoke on "Surgery of Horizontal Strabismus." A business meeting followed the lecture.

Milwaukee Roentgen Ray Society

New officers of the Milwaukee Roentgen Ray Society for the 1967–1969 term are: president, *Dr. Harold F. Ibach;* vice-president, *Dr. Alan B. Fidler;* and secretary–treasurer, *Dr. James E. Bell,* all of Milwaukee.

Milwaukee Ophthalmological Society

Members of the Milwaukee Ophthalmological Society gathered at the University Club following the State Medical Society Ophthalmological Sectional meeting for a dinner meeting May 11. Guest speaker was Dr. Lorenz Zimmerman, chief of the Department of Ophthalmic Pathology, Armed Forces Institute of Pathology, Washington, D. C. His topic was "Errors in the Diagnosis of Malignant Melanoma of the Choroid and Ciliary Body."

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Wisconsin Anti-Tuberculosis Association

Dr. Helen A. Dickie, chief-of-staff of the University of Wisconsin Hospitals in Madison, was elected president of the Wisconsin Anti-Tuberculosis Association at its annual meeting March 30 in Milwaukee. Charles W. Chapman, West Bend, was named president-elect; *Dr. Edward A. Bachhuber* of Milwaukee, vice-president; *Dr. Elwood W. Mason* of Milwaukee, secretary; and Asher B. Nichols, Jr. of Milwaukee, treasurer.

Reelected to the board of directors were Doctor Mason, Mr. Nichols, *Dr. George C. Owen* of Milwaukee, Mrs. Margaret Browne of Manitowoc, Robert Spears of Washburn, and *Dr. James M. Wilkie* of Madison.

Named as a new member of the board was Melvin C. Reppen, Madison. In another action, the association passed a resolution opposing a merger of the Wisconsin State Board of Health with the State Department of Public Welfare, as proposed by the Kellett Committee.

The association's 1967 distinguished service award went to *Dr. John K. Shumate*, Madison, administrative and medical head of Lake View Sanatorium in Madison from 1942 until it closed last year.

Doctor Shumate, who has served in Wisconsin for 35 years, has worked longer than any other doctor as a Wisconsin TB sanatorium superintendent and medical director.

Wisconsin Heart Association

The Wisconsin Heart Association's Annual Meeting and Leadership Workshops were held April 29 at the Sands Motor Inn, Milwaukee. Heart leaders from all over the state gathered for the session which had as its theme: How to Reduce the Risk of Heart Attack.

Dr. Thomas Puchner, Milwaukee cardiologist, was chairman of the committee handling the meeting. Serving with him were John Canfield, Madison; *Dr. Joseph B. Grace*, Green Bay; Laurence C. Hammond, Jr., Milwaukee; Mrs. Frank Klode, Milwaukee; Miss Edith May, R.N., Madison; and Miss Alice Topzant, R.N., Milwaukee.

Luncheon speaker for the corporate meeting was U.S. Senator William Proxmire. A President's Reception, honoring outgoing president, *Dr. Hugh J. McLane* of Fond du Lac, and incoming president, John Canfield of Madison, was held prior to the luncheon.

A nurses scientific program and a volunteer leadership program on implementation of risk factor programs in the community also were held. Miss Edith V. Olson, R.N., associate professor and coordinator of medical-surgical nursing at the University of Colorado Nursing School, was the speaker for the nurses program.

Speakers at the volunteer program were *Dr. Raymond Rice* of Milwaukee who discussed "The Heart Story" and *Dr. Thomas Puchner* of Milwaukee who discussed "How to Reduce the Risk of Heart Attack."

Dr. Thomas Meyer, assistant dean of the University of Wisconsin Medical School, Madison; *Dr. Fred Fletcher*, Marshfield; *Dr. Richard Wasserburger*, cardiologist at the Veterans Administration Hospital in Madison; and *Dr. Robert Green*, practicing internist at the Gundersen Clinic at La Crosse, participated in the leadership workshop discussions on implementation of new concepts in program and fund raising.

Physicians whose names appear in italics are members of the State Medical Society.

PARAMEDICAL ANCILLARY GROUPS

New Riverview Hospital Dedicated

A dedication program and open house of the newly completed Riverview Hospital at Wisconsin Rapids were held April 1 and 2. Governor Warren Knowles gave the dedicatory address and participated in the cornerstone laying on April 1 with the open house on April 2.

A special supplement to the WISCONSIN RAPIDS DAILY TRIBUNE was distributed March 31. It contained 16 pages of interesting information on the hospital development, its services and facilities, and administration; and a review of the medical progress in the community. A feature on the State Medical Society of Wisconsin and its Museum of Medical Progress at Prairie du Chien was included.

Medical history of the area was reviewed; it included the Pomainville family which boasts of nine doctors on the family tree.

The medical staff of Riverview Hospital consists of the following physicians: *A. W. Wittchow*, president; *C. H. Starr*, secretary-treasurer; *R. L. Johnson*, president-elect; *A. M. Lucas*, past president; *W. L. Nelson, R. E. Garrison, L. C. Pomainville, H. G. Pomainville, E. E. Debus, E. C. Glenn, A. W. Hulme, J. W. Schaller, C. J. Arendt, N. W. Arendt, J. E. Thompson, L. R. Pfeiffer, William Allen, C. F. Wood, A. M. Kohn*, J. J. Roubik, *Angelo Milano*, and *Francesco Sciarrone*.

AHA Forms Stroke Council

The formation of a Council on Cerebrovascular Disease by the American Heart Association was announced recently by *Dr. Hugh J. McLane*, Fond du Lac, president of the Wisconsin Heart Association. This brings to nine the number of scientific councils functioning within the American Heart Association as professional societies with subspecialty interests in the cardiovascular field.

The new Council is an outgrowth of the Association's Coordinating Committee for Nationwide

Stroke Program. It will initiate and coordinate national and local programs of research, graduate and undergraduate medical education, allied professional education, public education and information and community services.

Serving as the Council's officers are: Dr. Clark H. Millikan of the Mayo Clinic, Rochester, Minn., chairman; and Dr. John W. Goldschmidt of Jefferson Medical College and Hospital, Philadelphia, vice-chairman.

The Association's eight other Councils cover arteriosclerosis, basic science, cardiovascular surgery, circulation and renal diseases, clinical cardiology, epidemiology, high blood pressure research, and rheumatic fever and congenital heart disease.

Cancer Grants to Milwaukee Scientists

Research grants totaling $13,626 have been awarded to four Milwaukee medical scientists by the Milwaukee Division of the American Cancer Society. They are $2,900 to George A. Marzluf, an assistant professor of biology at Marquette University; $6,000 to *Dr. Roland A. Pattilo*, an instructor in gynecology at the Marquette medical school; $2,750 to *Dr. Stuart D. Wilson*, an assistant professor of surgery at the medical school, and $1,976 to *Dr. Mortimer M. Bortin*, an associate clinical professor of medicine, conducting research at Mount Sinai Hospital.

U.W. Medical School Plans Cancer Cytology Course

The University of Wisconsin Medical School's department of preventive medicine is accepting applications for its 1967–1968 course in the cytology of cancer.

The 12-month course, to begin next September 11, concentrates on the diagnosis of cancer through analysis of human cellular material. Successful applicants will receive U.S. Public Health Service traineeships which carry stipends of $225 per month during the duration of the course.

The course, approved by both the College of American Pathologists and the Board of Schools of Medical Technologists, is divided into two six-month sessions. The first portion includes formal laboratory instruction, with lectures, conferences, and training in the microscope. The second session comprises a supervised screening period, during which trainees work under the direction of experienced cytotechnologists.

Applicants must have completed at least two years of college and must have at least 12 credits in biology. A transcript of college grades must be submitted with each application.

Upon completion of the course, students receive a certificate of training and are eligible to take the certification examinations of the Registry of Medical Technologists.

Requests for application forms and additional information may be directed to *Dr. S. L. Inhorn*, director, school of cytotechnology, department of preventive medicine, University of Wisconsin, Madison 53706.

Wisconsin League for Nursing

Dr. William S. Middleton, consultant in research and education at the Veterans Administration Hospital in Madison, spoke April 6 at the annual meeting of the Wisconsin League for Nursing, Inc., at the Park Motor Inn, Madison. Doctor Middleton spoke on "The Dynamic Health Field."

Others on the program included Mrs. Beatrice Chase, assistant director, Department of Hospital Nursing, National League for Nursing, New York; Dr. Frank Reider, Section on Preventable Diseases, Wisconsin State Board of Health, and Lulu Wolf Hassenplug, dean of the School of Nursing, UCLA Center for Health Sciences, Los Angeles. More than 350 members and guests were registered.

UW Survey on Country Air Pollution

Rural persons in 38 Wisconsin counties were interviewed during March by representatives of the University of Wisconsin Survey Research Laboratory in Madison. The survey included some breathing tests to determine the extent of chronic lung diseases, including emphysema.

The survey is of major interest to Drs. Robert A. Barbee, *Helen A. Dickie*, and *John Rankin* of the UW Medical School faculty because "in the past several years, doctors working in the pulmonary section of the school have become increasingly alarmed at the number of patients they have seen who have lung diseases which are directly related to the dust-filled air they breathe on the farm," Doctor Barbee noted.

"We hope to pinpoint the activities on the farm which are most dangerous from the standpoint of

Lions Pledge Fund for Eye Surgery Room at Hospital

The Wisconsin Rapids Lions Club in March pledged $15,000 to finance the cost of completely equipping an eye, ear, nose, and throat operating room at the new Riverview Hospital in Wisconsin Rapids.

J. Peter Hamel, hospital alministrator, told the Lions that the new facilities purchased by their gift will make it possible to perform the type of surgery at Riverview that before could not be performed in the central Wisconsin area because of lack of equipment.

The Lions Club is noted for its generous support of sight-saving organizations and activities. Last year the club donated $1,200 to various eye care and related projects. It continues to sponsor projects such as the purchase of eyeglasses to the needy, financing eye operations, and support of the camp for the blind at Rosholt.

air pollution, and to provide an insight into how this danger may be lessened."

Interviewing was conducted in the following counties: Adams, Bayfield, Barron, Brown, Clark, Crawford, Dane, Door, Eau Claire, Fond du Lac, Forest, Green Lake, Grant, Lafayette, Langlade, Marathon, Menominee, Milwaukee, Price, Richland, Racine, Rusk, Oconto, Ozaukee, Polk, Sawyer, Sheboygan, Sauk, Shawano, St. Croix, Taylor, Trempealeau, Vernon, Vilas, Waushara, Waupaca, Washington and Washburn.

Medical Technology Intern Training Program

St. Elizabeth Hospital in Appleton will begin a medical technology intern training program July 1, it was announced at a hospital auxiliary annual meeting March 20. Sister M. Veronica and *Dr. James Erchul* explained the program to 75 women attending the meeting. Doctor Erchul is director of Laboratory and School of Medical Technology at St. Elizabeth's.

The school has been approved for six students. Three will be accepted the first year. Classes will meet eight hours a day, five days a week, 52 weeks a year.

Fond du Lac County Unit of ACS

Dr. Harvey Sharpe, Jr. of Fond du Lac was the guest speaker March 28 at the Fond du Lac County Unit of the American Cancer Society's kickoff meeting for the annual crusade for funds. A new cancer film, "Investment in Life," was viewed by 40 volunteer workers.

Eau Claire County Unit of ACS

Dr. William Walter, crusade chairman for the Eau Claire County Unit of the American Cancer

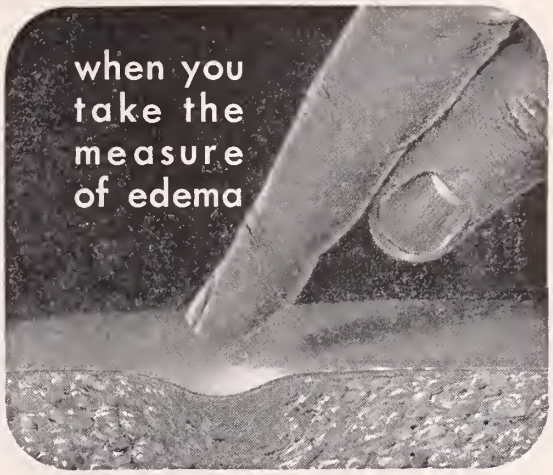
Hospital Council Studies Nursing Education

The Hospital Council of Greater Milwaukee Area at its Board of Directors meeting Thursday (April 13, 1967) discussed the enrollment of students in various nursing programs. In conjunction with a major recruitment effort, a special committee was formed to study ways of strengthening all nursing education programs with a particular view toward cooperative effort.

The Wisconsin Hospital Association was specifically requested to ask for legislation to give financial support to all nursing education programs.

A special committee was also appointed to study how nurses may be used more efficiently.

The Hospital Council voted to recommend to its member hospitals that registered nurses' starting salaries be increased from $475 to $540 per month effective September 1, 1967. This increase has been studied for two months by personnel specialists. This action will probably affect other hospital employees' salaries.



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WARNINGS: Use with caution in the presence of renal disease as azotemia may be precipitated or increased. In patients with advanced hepatic disease, electrolyte imbalance may result in hepatic coma. Dosage of coadministered antihypertensive agents should be reduced by at least 50%. In cases of suspected electrolyte imbalance, serum electrolyte determinations should be performed and imbalance, if any, corrected. Stenosis or ulcer of small intestine have been reported with coated potassium formulas, and surgery has been required and deaths have occurred. Based on surveys of both United States and foreign physicians, incidence of these lesions is low and a causal relationship in man has not been definitely established. Until further experience has been obtained, the use of the drug in pregnant patients should be weighed against possible hazards to the fetus.

CONTRAINDICATIONS: AQUATAG (benzthiazide) is contraindicated in progressive renal disease or dysfunction including increasing oliguria and azotemia. Continued administration of this drug is contraindicated in patients who show no response to its diuretic or antihypertensive properties. Severe hepatic disease is a relative contraindication. (See "Warnings" above.)

PRECAUTIONS AND SIDE EFFECTS: Electrolyte imbalance with hypokalemia (digitalis toxicity may be precipitated), hypochloremic alkalosis and hyponatremia may occur. Patients with cirrhosis should be observed for impending hepatic coma and hypokalemia. Other reactions may include blood dyscrasias, hyperuricemia and gout, nausea, jaundice, anorexia, vomiting, diarrhea, dizziness, paresthesia, photosensitivity and headache. Hepatic fetor, tremor, confusion and drowsiness are signs of impending pre coma and coma in patients with cirrhosis. Insulin requirements may be altered in diabetes. AQUATAG (benzthiazide) should be used with caution post-operatively as hypokalemia is not uncommon. Potassium supplementation may be advisable pre- and post-operatively. There have been occasional reports of thrombocytopenia, leukopenia, agranulocytosis, aplastic anemia and precipitation of acute pancreatitis or jaundice.

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PARAMEDICAL/ANCILLARY *continued*

Society, opened the annual April kickoff meeting by expressing the need to expand the society's program. *Dr. David Angell* reported on the types of cures for cancer and the importance of acquainting the public with the danger signals. The meeting was held April 10 at Sacred Heart Hospital in Eau Claire.

Cancer Detection Promoted

Photo courtesy WISCONSIN STATE JOURNAL

The American Cancer Society's 1967 crusade theme is "Procta: The Cancer Lifesaver We Don't Use" and is aimed at encouraging examinations to detect cancer of the rectum and colon. *Dr. William B. Hobbins*, foreground, president of the Dane County Unit, Madison, gives instructions to other crusade leaders about the literature to be distributed as part of the campaign. Seated are Mrs. Chris P. Lemberg, Madison residential crusade chairman, and Robert Collins, annual crusade chairman. Standing are Russell McCarthy, left, in charge of the Dane County rural areas, and Roger Koby, right, in charge of the independent business campaign. Similar campaign's are taking place throughout the state with the cooperation of the Wisconsin Division of the ACS. A special feature appears elsewhere in this issue explaining the Cancer Society's efforts in encouraging physicians to include the proctosigmoidoscopic examination as a routine procedure and results of a recent survey.

Blood Pressure Public Forum

A public forum on "You and Your Blood Pressure" was held April 26 at the Dane County Fairgrounds in Madison. *Dr. Ovid O. Meyer*, chairman of the Dane County Unit of American Heart Association and a professor of medicine at the University of Wisconsin, was moderator of the program.

An expert on high blood pressure, Dr. Louis N. Katz, spoke at the forum which was co-sponsored by the heart unit and Madison Newspapers, Inc. Doctor Katz is director of the Cardiovascular Institute at Michael Reese Hospital and Medical Center, Chicago.

Those attending were allowed to submit questions about high blood pressure and its relationship to heart disease to the panel of speakers.

Dane County Cancer Unit

At a tea at the Executive Residence in Madison in early April, ward volunteer leaders of the Dane

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Dosage—*Adults:* Mild to moderate psychoneurotic reactions, 2 to 5 mg b.i.d. or t.i.d.; severe psychoneurotic reactions, 5 to 10 mg t.i.d. or q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; muscle spasm with cerebral palsy or athetosis, 2 to 10 mg t.i.d. or q.i.d. *Geriatric patients:* 1 or 2 mg/day initially, increase gradually as needed and tolerated. (See Precautions)

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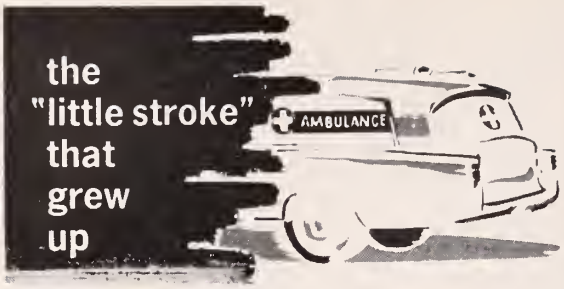

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[1] Gale, E. T. and Thewlis, M. W., Geriatrics 8:80, 1953
[2] Personal Communication: R. C. Brunner, Pharmaceutical Div., Sunkist Growers

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PARAMEDICAL/ANCILLARY *continued*

County Unit of the American Cancer Society were briefed on the objective of this year's cancer crusade held April 17–20.

Dr. Harold P. Rusch, director of McArdle Laboratory, University of Wisconsin Medical Center, was keynote speaker. He discussed some of the progress that is taking place in cancer research at McArdle Laboratory, that last year received $728,000 from the American Cancer Society for cancer research.

Dr. William B. Hobbins, president of the Dane County Unit, spoke on the success the Madison area has had in controlling cancer by means of early diagnosis through the Pap smear test and chest x-ray films and stressed the importance of annual proctoscopic examinations to detect cancer early enough for effective preventative measures. A special article on this subject appears elsewhere in this issue.

Arthur H. Mennes, director of curriculum of the Madison School System who has been active in the Cancer Society for 10 years, discussed the progress of cancer education in the Dane County schools. He stated that as of this year, every school in the county has had some cancer education.

Ozaukee–Sheboygan Medical Assistants

Dr. Raymond H. Evers, superintendent and medical director of Rocky Knoll Sanitorium and Hospital, spoke to Ozaukee–Sheboygan County Medical Assistants Society March 28 in Citizens Hall of Citizens Bank of Sheboygan.

Hearings Tests: Pioneering Program

Two Sheboygan hospitals have established a program to detect hearing losses shortly after birth, one of the first such programs in the nation. Memorial and St. Nicholas hospitals have trained personnel who check the newborn and if the baby fails the test, which is performed without touching the infant, his physician is informed so there can be more observation and testing.

Eye Bank Association of America

The means of obtaining donor eyes for corneal transplant surgery and for research brought eye physicians, ham radio operators, and members of Lions service clubs to Milwaukee, April 15 to 16, for the annual north central regional meetings of the Eye Bank Association of America.

Sixty to 70 representatives from 9 midwestern states attended the meetings at the Holiday Inn Central. The Wisconsin Lions Foundation, Inc. in affiliation with the Milwaukee Blood Center and the Marquette medical school department of ophthalmology were sponsors.

Dr. Richard O. Schultz, surgical director of the Wisconsin Lions eye bank and chairman of the Marquette medical school eye department, said the group discussed procedures for making eyes available to patients who need corneal surgery and for medical research.

The emergency need for eyes in areas where they are not available is handled by the Eyebank Network System, a nationwide group of ham radio operators who make "radio rounds" twice daily with each other. They contact and are contacted by an eye bank as needed.

A report on one area of corneal research being done at the Marquette Medical School corneal research laboratory was given by Dr. Henry Edelhauser, who is a physiologist and research associate in the eye department. Doctor Edelhauser discussed research on keratoconus.

The Wisconsin eye bank is located at the Milwaukee Blood Center, 763 N. 18th. Nine substations throughout the state are qualified to receive eyes which are then sent to the central facilities at the blood center for distribution. They are located at Waukesha, Beloit, Burlington, Chippewa Falls, Cudahy, Menomonee Falls, Oconomowoc, Wausau, and Watertown. Lions clubs in these cities sponsor activities of the local bank, according to V. J. Lucareli, Kenosha, executive director and chairman of the Wisconsin Lions eye bank.

Elected Officers, State Board of Health

Dr. Frank E. Drew of Milwaukee was elected president of the Wisconsin State Board of Health and Dr. Irving J. Ansfield, also of Milwaukee, was elected vice-president at the regular monthly meeting of the Board April 7. Doctor Drew is a pediatrician and Doctor Ansfield is an obstetrician. Doctor Drew this month completed a one-year term as president of the State Medical Society.

Dr. Hirschboeck Speaks at La Crosse

Dr. John S. Hirschboeck of Milwaukee, director of the newly formed Wisconsin Regional Medical Program, spoke to 75 persons attending the Adolf Gundersen Medical Foundation dinner in La Crosse March 23.

Doctor Hirschboeck told the group that health care in the United States by the mid-1970s is expected to involve more persons than any other field, including construction and agriculture. These are turbulent times in medicine, he said, and actions today will strongly determine future medical-hospital performance, some of it having worldwide implications.

A special article on the Wisconsin Regional Medical Program by Doctor Hirschboeck appears elsewhere in this issue.

Dr. Bachhuber Active in Cancer Drive

Dr. M. W. Bachhuber of Mayville is a member of the Dodge County Cancer Society's board of directors which spearheaded a countywide crusade in April to raise funds for education, research, and service.

State Board of Health

At its regular monthly meeting in Madison April 7, the State Board of Health indicated its support of Senate Bill 241 relating to family planning.

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In other legislative matters reviewed at the meeting the Board indicated support of Assembly substitute amendment 2 to Assembly Bill 143 relating to a measles immunization program to be administered by the State Board of Health. It supported the principle of implied consent as contained in Senate Bill 82, the highway safety bill.

The Board also supported the addition of an osteopathic physician and surgeon, licensed to practice medicine and surgery in Wisconsin, to both the Advisory Hospital Council and to the Advisory Committee on Hospital Standards as contained in Assembly Bills 456 and 457.

Unique Scholarship Plan Instituted By Doctors Hospital

A new approach to meeting the growing, urgent need for nurses has been instituted by Doctors Hospital of Milwaukee in the form of a unique Scholarship Plan.

The Hospital realizes there are many capable high school students with the desire to serve in the nursing profession who would find it extremely difficult—if not impossible—to obtain the necessary training without financial assistance.

Rather than lose these potential assets to the nursing profession, the Board of Trustees of Doctors Hospital is offering tuition scholarships to students (both men and women) seeking to become Registered Nurses and Licensed Practical Nurses.

Applications for scholarships may be obtained by writing to Walter Harden, Administrator, Doctors Hospital, West Wells at North Twenty-Eighth Street, Milwaukee, Wisconsin 53208.

Medical–Moral Problems Issue

Increasing medical-moral problems have been brought about by modern medicine, a minister who heads the American Medical Association's department of medicine and religion said in Milwaukee April 5 at the opening session of a two-day conference on medical-moral problems.

The Rev. Paul B. McCleave, LL.D., Chicago, a Presbyterian minister, indicated that clergymen should help physicians solve such difficulties.

The conference was conducted by the Marquette University division on continuing education and its medical school, and was sponsored by the Minnesota Conference of Catholic Hospitals.

Cancer Conference for Nurses

The Sixth Annual Cancer Conference for Nurses was attended by 545 nurses from Wisconsin and neighboring states, April 1 at the Holiday Inn No. 2 in Madison. Jointly sponsored by the University of Wisconsin and the Wisconsin Division of the American Cancer Society, the conference looked ahead at the future of cancer therapy.

UNIV. OF WISCONSIN MEDICAL SCHOOL REVISES CURRICULUM

A major revision in the University of Wisconsin Medical School curriculum, which will give students a wider opportunity to choose their course work, was approved recently by the Madison campus faculty.

The changes provide for a somewhat reduced number of hours of assigned time for first-year students, a reorganization of course sequences, and the introduction of some second-year courses the first year.

A curriculum committee, headed by Dr. R. D. Coye, proposed the changes following a two-year study. Doctor Coye is an assistant dean of the Medical School. His committee members were Drs. Mark Hansen, William Lewis, Warren Dennis, David Slautterback, James Whiffen, John Benfield, and Arvin Weinstein.

According to the committee, the revisions produced a curriculum which will recognize the medical student as a graduate student. He will be given wide opportunity, especially in the fourth year, to pursue individual interests in elective studies.

The curriculum also organizes the entire four-year program as a coherent whole—with each subject treated as an important building block in the structure of medical education.

In its revisions, the committee was aided by other faculty members in a content study of each lecture delivered in the Medical School. A computer assisted the investigators in organizing data.

In addition to more individual programs, the committee said the new curriculum presented these advantages: a reduction of class and laboratory time; the elimination of overlapping course work; more and earlier patient contact, and the deliberate relationship of subject matter to medical phenomena encountered by the student.

But the most important departure from traditional medical education, the committee stated, lies in the new curriculum's recognition of medical education as a "school-oriented" rather than a "subject-oriented" process.

"The sum of a series of isolated courses," said Doctor Coye, "does not produce as desirable an educational result as a four-year curriculum planned with the overall educational needs of medical students as a foremost consideration."

The new curriculum is expected to become effective for first-year students in the fall of 1968.

Dr. Robert J. Samp, moderator and program chairman, told the group: "I have a great feeling of hope; we're attempting things that couldn't have been attempted a few years ago." He said that in the future a specialist-nurse will have to be developed to handle only cancer patients. Doctor Samp is assistant professor of surgery and Division of Clinical Oncology, UW Medical Center.

Another speaker at the conference, Dr. Daniel Tobin, talked to the nurses about the hyperbaric chamber and other approaches to therapeutic radiation by x-ray.

Dr. Fritz Bach, assistant professor of medical genetics at the University of Wisconsin, discussed immunology and its relation to cancer. Dr. Archie MacKinney, assistant professor of medicine at the UW, discussed the rising volume of leukemia cases.

Others on the faculty included Mrs. Josephine K. Craytor, R.N., B.S., M.S., associate professor of nursing, University of Rochester, N.Y.; Attorney Francis Wilcox, Eau Claire, past chairman of the board, (National) American Cancer Society, Inc.; Dr. Patricia A. Joo, UW Department of Pediatrics and *Dr. Robert O. Johnson*, UW Department of Surgery.

Medical Self-Help Training Course

An extensive program on "Medical Self-Help" is being conducted at Green Bay Vocational and Adult School from April 3 to May 23. The course is designed primarily for licensed practical nurses as a continuing education program.

A faculty of four includes *Dr. John H. Randall*, Green Bay internist. Sponsors of the course are: Green District, Licensed Practical Nurses Association; Green Bay Vocational and Adult School; Brown County Heart Unit of the Wisconsin Heart Association; Brown County Medical Society; and Brown County Emergency Government.

Summer Camp For Diabetic Children

The SUMMER CAMP FOR DIABETIC CHILDREN will be conducted for the nineteenth year under the auspices of the Diabetes Association of Greater Chicago from July 16 through August 6 at Holiday Home, Lake Geneva, Wisconsin. Boys and girls from eight thru thirteen years of age are eligible.

As in previous years, the camp will be staffed by resident physicians, a nurse, dietitians and laboratory technicians, in addition to the regular counseling and domestic staff of Holiday Home.

Rates for SUMMER CAMP are arranged in accordance with individual circumstances. Applications may be obtained from, and inquiries should be directed to:

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OBITUARIES

Dr. Salvatore Randazzo, 68, Wauwatosa, died Sept. 10, 1966, in Wauwatosa. Doctor Randazzo graduated from the University of Palermo (Italy) in 1923 and took his residency in Traverse City, Michigan.

Dr. E. J. Brown, 80, a former Madison physician, died Jan. 14, 1967, in Fort Lauderdale, Fla., where he had resided since retiring in 1940. He is survived by his widow, Vernice.

Dr. John P. Kelly, 66, a Pewaukee physician and surgeon for 34 years, died Jan. 25, 1967, in Milwaukee.

Born in Madison, he was graduated from the Marquette University School of Medicine in 1933 and interned at Milwaukee County General Hospital.

Doctor Kelly was a member of the Waukesha County Medical Society, State Medical Society of Wisconsin, American Medical Association, and past president of the Marquette University Medical Alumni Association.

Surviving are his widow, Marie; two sons, John J., a medical student at Marquette University and Paul F., a Peace Corps worker in Africa and a daughter, Kathleen, who teaches in Milwaukee.

Dr. Harry R. Ausman, 63, who had practiced in Milwaukee since 1930, died Jan. 26, 1967, in Milwaukee.

Born in New York City, Doctor Ausman received his M.D. degree from the Marquette University School of Medicine in 1929 and interned at Milwaukee Hospital.

He was a member of The Medical Society of Milwaukee County, State Medical Society of Wisconsin, and American Medical Association.

Surviving are his widow, Ione; and two daughters, Mrs. Nancy Dubin of Bayside and Mrs. Donna Cooper of Fox Point.

Dr. Anthony Z. Domine, 73, Middleton, retired staff member of the Madison General Hospital, died Feb. 16, 1967, in Madison.

Born in New Jersey, he attended City College, New York, and graduated from Temple University in Pennsylvania in 1919. He came to Madison and worked with the servicemen at Mendota State Hospital. Doctor Domine returned to New Jersey in 1926 and worked in private practice until 1941 and then came back to Madison where he served on the staff of the Madison General Hospital until 1954 when he retired.

He was a member of the Dane County Medical Society, State Medical Society of Wisconsin, and American Medical Association.

Surviving are his widow, Della, and a son, Vincent of Middleton.

Dr. Charles F. Burke, 65, who had practiced internal medicine with the Dean Clinic in Madison, died Feb. 16, 1967.

Doctor Burke was a 1928 graduate of the University of Wisconsin Medical School, interned at St. Mary's Hospital, Madison, and was a fellow in internal medicine at the Mayo Clinic, Rochester, Minn., before joining the Dean Clinic in 1932.

He was a member of the Dane County Medical Society, State Medical Society of Wisconsin, and American Medical Association.

Doctor Burke is survived by two sisters, Miss Elizabeth and Miss Helen Burke, both of Chicago.

Dr. A. J. Hockett, 61, Mosinee, died Feb. 26, 1967. Prior to coming to Mosinee he had practiced in Wallowa, Ore. He was a medical director of the Touro Hospital, New Orleans, La., for 10 years and of the King County Hospital, Seattle, Wash., for three years, and also a consultant for the Oak Ridge, Tenn., Atomic Energy plant before assuming general practice in Wallowa.

Doctor Hockett graduated from the University of Oregon Medical School in 1929 and took his internship and residency at the University of Wisconsin General Hospital, Madison. He was a member of the Marathon County Medical Society, State Medical Society of Wisconsin, and American Medical Association.

Surviving are his widow and one daughter, Mrs. Wade Johnson, Portland, Ore.

Dr. William C. McCormick, 73, a Tomahawk physician for 44 years, died Feb. 28, 1967. Doctor McCormick took his premedical training at Valparaiso and George Washington universities and graduated from Loyola University, Chicago, in 1916. He entered the army in 1917 and was discharged in 1919 and resumed his practice in Tomahawk. Doctor McCormick was honored by the State Medical Society of Wisconsin and the American Medical Association last spring for his 50 years of service as a doctor. He was also a former president of the Lincoln County Medical Society and in 1956 served as chief-of-staff of Sacred Heart Hospital in Tomahawk.

Doctor McCormick is survived by his widow; three daughters, Mrs. Dorothy Dettmering of Mukwonago, Mrs. Elmer Crespi of Sacramento, Calif.; Mrs. Albert McGinley of Huntington Beach, Calif.; and a son, William C., Jr. of Phoenix, Ariz.

MEMORIAL GIFTS . . . .

. . . to the Charitable, Educational and Scientific Foundation of the State Medical Society of Wisconsin serve both the living and pay thoughtful tribute to the memory of a friend, relative, or colleague. A Memorial Card will be sent to the bereaved family. You, as donor, will be mailed a receipt.

SOCIETY RECORDS

MEMBERSHIP REPORT AS OF MARCH 29, 1967

NEW MEMBERS

Aronow, Cedor B., 9 LeMay Street, Fort Bragg, North Carolina
Balistrieri, James J., 8700 West Wisconsin Ave., Milwaukee 53226
Buttles, Anson J., 236 East Chateau Place, Milwaukee 53217
Franzen, Lyle D., 515 West Moreland Blvd., Waukesha 53186
Gardner, Weston D., 561 North 15th St., Milwaukee 53233
Gascoigne, James T., 1912 Atwood Ave., Madison 53704
Gingrass, Ruedi P., 8700 West Wisconsin Ave., Milwaukee 53226
Goldstein, Frank P., 312 Seventh St., Racine 53403
Kastelic, Robert, 1729 South 11th St., Milwaukee 53205
Koepke, Glenn H., St. Croix Falls Clinic, St. Croix Falls 54024
Lagus, Arne T., St. Croix Falls Clinic, St. Croix Falls 54024
Leite, Joaquim, V. A. Center, Wood 53193
McLeod, Paul A., 30 South Henry St., Madison 53703
Petersen, Roger D., 100 South Washington, Elkhorn 53121
Peterson, Evan H., St. Croix Falls Clinic, St. Croix Falls 54024
Pratt, Mary Van Horn, 921—16th Ave., Monroe 53566
Propeck, Stephen L., 968 North 123rd St., Wauwatosa 53226
Rank, Philip P., 1300 University Ave., Madison 53706
Restrepo, Roberto, 15680 West Brentwood Drive, Brookfield 53005
Ridley, John E., 2510 West Capitol Drive, Milwaukee 53206
Salama, E. M., 8700 West Wisconsin Ave., Milwaukee 53226
Stenberg, Clayton C., 921—16th Ave., Monroe 53566
Taugher, Philip J., 6400 West Conifer, Greendale 53129
Thompson, John R., 207 Main Street, Wautoma 54982
Young, Charles W., 470 North Charter Street, Madison 53706

CHANGES OF ADDRESS

Bailey, Douglas W., 3221 West Vogel Ave., Milwaukee 53221
Bayley, H. G., 138 Front St., Beaver Dam 53916
Boldon, Edward I., Jr., 20 South Park St., Madison 53715
Boock, R. F., 138 Front Street, Beaver Dam 53916
Calloway, Nathaniel O., 3100 Lake Mendota Dr., Madison 53705
Capelli, Paul A., 1400—75th St., Kenosha 53140
Chopyak, John A., Milwaukee, to U. S. Naval Hospital, Camp Pendleton, Calif. 92055
Cook, Harold E., Milwaukee, to 12325 Fries Lane, Wind Lake 53185
Cook, R. Sanford, 138 Front Street, Beaver Dam 53916
Cordes, John E., 5757 West Oklahoma Ave., Milwaukee 53219
Corso, Xavier, 221 East Third St., Beaver Dam 53916
Erickson, N. W., 1200 East Third St., Beaver Dam 53916
Fechter, Frank J., 7456 North Crossway, Milwaukee 53217
Funcke, Wm. E., 1200 North Center Street, Beaver Dam 53916
Galang, Luis L., Watertown, to Algoma Clinic, Algoma 54201
Gorenstein, L. M., La Crosse, to P. O. Box 535, Matlacha Station, Fort Myers, Florida 33901
Harkness, John W., 561 North 15th St., Milwaukee 53233
Heyrmann, Donald J., W137 N7657 North Hills, Menomonee Falls 53051
Jasculca, Jerry H., San Francisco, to Kern County General Hospital, 1830 Flower St., Bakersfield, Calif. 93305
Klees, Vanna M., 7607 North Lake Drive, Milwaukee 53217
Klomberg, Gerald, 219 West Third St., Beaver Dam 53916
Knight, Curtis C., 726 West Main Street, Madison 53715
Kramer, J. D., 400 Strollers Lane, Wausau 54401
Link, D. L., 1200 North Center St., Beaver Dam 53916
Madden, W. J., 4700 Light House Drive, Racine 53402
McGuire, G. E., 118 North Monroe Ave., Green Bay 54301
Meyer, Glenn A., Madison, to Walter Reed Army Institute of Research, Washington, D. C. 20012
Motamedi, Naghi, 945 North 12th St., Milwaukee 53233
Nellen, J. W., 118 North Monroe Ave., Green Bay 54301
Petters, W. J., 600 Fern Street, Waupun 53963
Pizer, Jerome A., Oak Creek, to 906 Lake Drive, South Milwaukee 53172
Rapkin, Mitchell A., 3414 Brighton Place, Madison 53713
Schrank, L. W., 600 Fern Street, Waupun 53963
Schrank, R. E., 600 Fern Street, Waupun 53963
Schulz, N. H., Horicon, to 1200 North Center St., Beaver Dam 53916
Sigalove, Wm. H., Fort Ord, California, to Ireland Army Hospital, Fort Knox, Kentucky
Simonsen, Thomas E., U. S. Army Hospital, 05-541-411, Zama, Japan, APO San Francisco 96343, California
Turner, C. Randolph, 1212 West Wisconsin Ave., Milwaukee 53233
Vrabec, A. P., 605 East South Street, Beaver Dam 53916
Wade, Chester, Delafield, to Cross Roads Motel, Elkhorn 53121
Ziolokowski, James S., 1730 North 70th St., Wauwatosa 53213

REMOVED FROM MEMBERSHIP

Bodmer, Robert E., Wood County, transferred to Nebraska
Burdette, Stella I., Polk County, resigned
Dillard, Andrew G., Wood County, transferred to Texas

SOCIETY RECORDS *continued*

Drexler, Charles J., Eau Claire–Dunn–Pepin County, transferred to Minnesota
Drischler, William H., Milwaukee County, transferred to California
Ferguson, Edward C., Dodge County, removed per county secretary
Gorrell, John E., Milwaukee County, resigned
Lauvstad, Walter A., Wood County, transferred to Montana
Myhre, Byron A., Milwaukee County, transferred to California

DEATHS

Randazzo, Salvatore, nonmember, Sept. 10, 1966
Brown, Ernest J., nonmember, Jan. 14, 1967
Hockett, A. J., Marathon County, Feb. 26, 1967
McCormick, William C., Lincoln County, Feb. 28, 1967
Rothman, Leonard E., Milwaukee County, Mar. 15, 1967

BOOKSHELF

New books received are acknowledged in this section. From these books, selections will be made for reviews in the interest of the readers and as space permits. Reviews are written by members of the faculty of the University of Wisconsin Medical School. Books here listed will be available on loan from the Medical Library Service, S.M.I. Building, North Charter Street, Madison, Wisconsin 53706

BOOKS RECEIVED

THE PRE-SCHOOL CHILD'S LEARNING PROCESS

Edward B. Rosenberg, B.S. and Silas L. Warner, M.D., Instructor in psychiatry, University of Pennsylvania Medical School; Consultant in Psychiatry, Swarthmore College; Associate Staff, Institute of Pennsylvania Hospital, Budlong Press Co., Chicago, Ill., 1967. 102 pages. Price: $1.50.

INFANT AND PERINATAL MORTALITY IN SCOTLAND

Vital and Health Statistics, U. S. Department of Health, Education, and Welfare, Washington, D.C., November 1966. Price: 35¢.

INFORMAL GROUP PROCESS IN SOCIAL WORK

By Esther Kovenock, A.C.S.W., consultant, Division of Child Behavior and Development, Wisconsin State Board of Health. Madison, Wis., 1966, 116 pages.

THE FEMININE MIND AND BODY

By J. Dudley Chapman, D.O., President of the American College of Osteopathic Obstetricians and Gynecologists and a Diplomate of the American Osteopathic Board of Obstetrics and Gynecology. Philosophical Library, Inc., New York, N.Y. 1967. 325 pages. Price: $6.95.

MODERN TREATMENT

Volume 2, No. 6. Treatment of Collagen Diseases, guest editor, Clarence E. Rupe, M.D.; and Treatment of Adrenal Disorders, guest editor, Don H. Nelson, M.D. Hoeber Medical Division, Harper & Row, Publishers, New York. Published bimonthly. 1,500 pages annually. Subscription: $16 per year.

PROGRESS AGAINST CANCER

A report by the National Advisory Cancer Council, 1966. U.S. Department of Health, Education, and Welfare, Washington, D.C. 72 pages. Price: 75¢.

INFANT, FETAL, AND MATERNAL MORTALITY

United States—1963. Vital and Health Statistics, data from the National Vital Statistics System. National Center for Health Statistics, Series 20, No. 3. U.S. Department of Health, Education, and Welfare, Public Health Service. September 1966. 64 pages. Price: 45¢.

AGE AT MENOPAUSE

United States—1960–1962. Vital and Health Statistics, data from the National Health Survey. National Center for Health Statistics, Series 11, No. 19. U.S. Department of Health, Education, and Welfare, Public Health Service. October 1966. 20 pages. Price: 25¢.

MORTALITY FROM DISEASES ASSOCIATED WITH SMOKING

United States, 1950–1964. Vital and Health Statistics, data from the National Vital Statistics System. National Center for Health Statistics—Series 20, No. 4. U.S. Department of Health, Education, and Welfare, Public Health Service, Washington, D.C. October 1966. 46 pages. Price: 35¢.

STATE DEFINITIONS OF LIVE BIRTHS, FETAL DEATHS

And gestation periods at which fetal deaths are registered. U.S. Department of Health, Education, and Welfare, Public Health Service, National Center for Health Statistics, Division of Vital Statistics, Washington, D.C. Third edition. May 1966. 59 pages.

NEW DRUGS—1966

Evaluated by AMA Council on Drugs. American Medical Association, Chicago. 1966. 592 pages. Price: $4; for medical students, interns, and residents—$3.

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MEDICAL MEETINGS

POSTGRADUATE COURSES

1967 WISCONSIN

Aug. 24–26: Conference on "Current Concepts in Surgery" sponsored by the Department of Surgery, UW Medical Center, at Wisconsin Center, Madison.

Sept. 14: Adolf Gundersen Medical Foundation and Wisconsin Heart Association Symposium on Stroke, at Wisconsin State University at La Crosse.

Sept. 15–16: Annual meeting, Wisconsin Society of Internal Medicine, The Gateway Hotel and Inn, Land O' Lakes.

Sept. 16–17: Annual fall meeting, Wisconsin Society of Anesthesiologists, The Pioneer, Oshkosh.

Oct. 16–20: Wisconsin Work Week of Health, State Medical Society of Wisconsin, Madison.

Oct. 16–21: Postgraduate course, "Basic and Clinical Aspects of Therapy in Advanced Cancer," University of Wisconsin Medical Center, Madison.

Oct. 21: Annual fall cancer conference (The Cancer Scrimmage), University of Wisconsin Medical Center, Madison.

Nov. 17: Medical-Legal-Industrial Symposium on "Pulmonary Diseases in Industry," sponsored by Mount Sinai Hospital, at Pfister Hotel, Milwaukee.

1967 NEIGHBORING STATES

July 28–29: Course on "New Concepts in Problems of Completed Stroke," American Rehabilitation Foundation, Minneapolis, Minn.

Aug. 14–18: Golden anniversary, American Dietetic Association, Conrad Hilton Hotel, Chicago, Ill.

Aug. 21–24: 69th Annual Meeting, American Hospital Association, International Amphitheater, Chicago.

Sept. 21–24: Annual meeting of American Medical Writers' Association, Palmer House, Chicago, Ill.

Oct. 2–6: Annual clinical congress, American College of Surgeons, Chicago.

Oct. 4–5: Annual Midwest Interprofessional Seminar on Diseases Common to Animals and Man, University of Missouri, Columbia.

Oct. 11: Third Annual Kidney Disease Symposium, Sheraton–Chicago Hotel, Chicago.

Oct. 12–13: Head and Neck Radiology Conference, Department of Radiology, College of Medicine of the University of Illinois, Chicago.

Oct. 14–20: Annual Otolaryngologic Assembly, at Illinois Eye and Ear Infirmary, Medical Center, Chicago.

1967 OTHERS

July 2–6: European Cancer Meeting, Vienna.

July 14–15: Rocky Mountain Cancer Conference, Brown Palace–West Hotel, Denver, Colo.

Sept. 29–Oct. 3: Annual meeting, American Society of Anesthesiologists, Las Vegas, Nev.

Nov. 16–19: Annual convention, National Society for Crippled Children and Adults, Century Plaza Hotel, Los Angeles, Calif.

1968 OTHERS

Jan. 14–18: Second annual meeting of the Society of Cryo-Ophthalmology, Miami Beach, Fla.

Oct. 21–25: Annual Clinical Congress, American College of Surgeons, Atlantic City, N.J.

For listing of other meetings see the JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION.

ADA Golden Anniversary Meeting in Chicago

Over 6000 persons will celebrate The American Dietetic Association's FIFTIETH Annual Meeting in Chicago, August 14–18. New discoveries in nutrition, diet therapy, food technology, food service management, and educational techniques will be among topics explored.

The Conrad Hilton, headquarters hotel, will be the site for sessions and the exhibition. Speakers on the program are nationally recognized authorities in nutrition, medicine, biochemistry, food industry, communication, management and education.

For further details, The American Dietetic Association, 620 North Michigan Ave., Chicago, Ill. 60611.

Kidney Disease Symposium, Chicago

The Third Annual Kidney Disease Symposium under the sponsorship of the Kidney Foundation of Illinois will be held on October 11 at the Sheraton–Chicago Hotel, in Chicago. Further details from, Kidney Foundation of Illinois, Inc., 127 North Dearborn Street, Suite 701, Chicago, Ill. 60602.

Annual Fall Cancer Conference

The 13th annual fall cancer conference (The Cancer Scrimmage) will be held Saturday, October 21, (the Wisconsin–Iowa Game) starting at 9 AM at the University of Wisconsin Medical Center. Cancer papers and reports on current clinical and basic research will be followed by a special guest speaker, a luncheon, and the football game. Registration notices will be sent out in August to State Medical Society members.

That same week (October 16–20) a five-day cancer chemotherapy course will be offered to a limited registration of physicians starting in the field. Further information is available for both programs from R. J. Samp, M.D., University Hospitals, Madison, Wis. 53706.

Problems of Completed Stroke

An innovation in continuing education will be used by the American Rehabilitation Foundation when it presents a course on "New Concepts in Problems of Completed Stroke," July 28–29 at the Kenny Rehabilitation Institute, Minneapolis.

In this path-breaking course on the patient with completed stroke, formal lectures have been abandoned. Instead the participant in the course is placed in as near the ideal learning situation as is feasible—at the patient's bedside. Emphasis is on active participation. The physician is asked to make diagnostic decisions and evaluations of the extent of the stroke, and to plan for patient management. The alternatives, with the likely consequences of each, are considered in class discussion.

The content of the intensive two-day course was determined after consultation with experts on stroke. The organization of material and manner of presentation are based on established principles of learning theory. In addition to actual patient demonstrations, teaching techniques used include videotapes, films, and taped recordings.

In order to allow every participant to take an active part, enrolment is of necessity limited to 20 physicians for each offering. The next offering is July 28–29 (Friday and Saturday). Applications will be accepted in order received. Tuition is $50. The course has been approved for 16 hours of prescribed credit by the American Academy of General Practice. To receive information or make application, write: Thomas P. Anderson, M.D., Kenny Rehabilitation Institute, 1800 Chicago Ave., Minneapolis, Minn. 55404.

American Congress of Rehabilitation Medicine

The 45th annual session of the American Congress of Rehabilitation Medicine will be held at the Americana Hotel, Bal Harbour, Miami Beach, Fla., August 27–September 1. The program includes multiple scientific sessions, a "Symposium on the Clinical Management of Disability: Nonarticular Rheumatic Pain Syndromes," the showing of the latest films on rehabilitation medicine, a "Session on Orthotics," and a hundred scientific and technical exhibits on the most recent research and clinical applications in the field of rehabilitation medicine.

In conjunction with this annual session of the Congress, the American Academy of Physical Medicine and Rehabilitation will hold its 29th annual assembly, August 28–29. This program includes a "Symposium on Peripheral Vascular Physiology and Disease," a "Symposium on Disabilities of Genetic Origin," and educational seminars on "Pulmonary Disabilities" and "Sports Injuries."

Dr. Allan J. Ryan of Madison, Wis., team physician for University of Wisconsin athletes, will participate in the educational seminar on sports injuries, Tuesday, Aug. 29, at 10:30 AM during the Academy's program.

Advance registration may be made with the ACRM, 30 N. Michigan Ave., Chicago, Ill. 60602.

Medical Aspect of Sports

The sixth postgraduate conference on medical aspect of sports will be held August 17–18 at the Frank W. Keaney Gymnasium, University of Rhode Island, Kingston. All team physicians, trainers, and coaches of college and university teams, and those of public, private, and parochial secondary schools, and all physicians with an interest in the subject may attend.

Sports Medicine Course

National authorities in the field of sports medicine will be lecturers at a special postgraduate course of the American Academy of Orthopaedic Surgeons, August 14–15–16 at the Skirvin Hotel, Oklahoma City, Okla.

For application forms and further information, physicians are asked to write to Dr. Don H. O'Donoghue, 1111 North Lee Street, Oklahoma City, Okla. 73103, or to the American Academy of Orthopaedic Surgeons, 29 East Madison Street, Chicago, Ill. 60602.

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1967 ANNUAL MEETING SUMMARY

THE ANNUAL SESSION of the House of Delegates was held on May 8, 9, and 10, 1967, in Milwaukee. The House considered resolutions introduced by county medical societies, the Council and AMA delegation, as well as reports of the Officers, Commissions, and various committees of the Society. Following are some of the highlights of the meeting as well as a summary of the actions taken:

REFERENCE COMMITTEE ON REPORTS OF OFFICERS

The House, on the basis of reports of Officers and Committees:

1. Accepted the Report of President Drew and commended him for his excellent efforts in representing the profession on the local, state, and national levels.
2. Adopted recommendations by President-elect Kief to (a) create a Commission to study pollution of the resources of our state, (b) have the Council create Commission status for the Division on Safe Transportation in view of the current interest being shown in this subject, (c) create a Division of the Commission on State Departments to deal with problems of alcoholism and addiction, and (d) ask the AMA delegation to meet with the Council prior to AMA meetings to discuss pending items and request that a minimum of three members of the delegation make a report to the Council and Officers after each AMA meeting.
3. Accepted the Report of the Secretary and agreed that the profession should continue to consider the implications and results of such subjects as abortion, human experimentation, and implied consent.
4. Accepted the Report of the Division on Chest Diseases and commended the Division for the role it played in the development of the report on "Recommendations on the Use of Tuberculin Tests and Chemoprophylaxis."
5. Endorsed the proposal of the Division on Maternal and Child Welfare to conduct perinatal

STATE MEDICAL SOCIETY "ROYALTY." President-elect, Dr. W. D. Jones of Oconomowoc; past president, Dr. F. E. Drew of Milwaukee; and president, Dr. H. J. Kief of Fond du Lac.

MEETINGS AND SPECIAL EVENTS HELD AT THE STATE MEDICAL SOCIETY "HOME" DURING THE MONTH OF MAY 1967

2 Board of Trustees, Delegates, and Alternate Delegates, Dane County Medical Society
2 Madison Anesthesiology Society
2 Madison Urological Society
3 Committee on Military Medical Service
4 State Board of Health (Madison)
5 Wisconsin Association on Alcoholism
6 Executive Committee, Council (Milwaukee)
7 Council (Milwaukee)
8 Annual Meeting (Milwaukee)
8 Executive Committee, Commission on Medical Care Plans (Milwaukee)
9 Annual Meeting (Milwaukee)
10 Annual Meeting (Milwaukee)
11 Annual Meeting (Milwaukee)
15 Madison Academy of Internal Medicine
18 Membership and ByLaws Committee, Wisconsin Association of Professions
20 State Universities Student Health Services
25 Commission on Scientific Medicine
25 Advisory Committee on Health Careers, Wisconsin Health Council
26 Health Career Conference and Tour, Students from Waukesha School
31 Planning Committee, Wisconsin Regional Medical Program

Meetings not held in the Society "Home" but have a direct relationship are printed in italics, with the location in parentheses.

INTERSTATE TEACHING AWARD. Walter Zeit, Ph.D. (right) of Marquette University School of Medicine, Milwaukee, was presented the Erwin R. Schmidt Interstate Teaching Award "for his outstanding qualities as a teacher of medical students, to prepare them far both the art of medicine, and in skills of diagnosis and treatment af the ill and troubled." The award, presented by Dr. Jahn M. Bell (left) af Marinette, representing the Interstate Pastgraduate Medical Assembly, is given annually by Interstate to a faculty member af one of the twa Wisconsin medical schaals upon recommendatian of the Cammissian an Scientific Medicine.

PRESIDENTIAL AWARD. Gavernor Warren P. Knawles (above) received the Presidential Citation from outgaing president, Dr. Frank E. Drew, wha cited Governor Knawles for "his steadfast work ta make Wisconsin a state about which we can sincerely proclaim: 'We Like It Here.' "

pilot studies; shared the concern of the Division over the lack of facilities in certain hospitals to meet obstetrical emergencies; and concurred with the idea of a joint study with the State Board of Health and the Wisconsin Hospital Association to alleviate the situation.

6. Accepted the Report of the Division on Handicapped Children which included information on the mobile otologic unit being sponsored by the Bureau for Handicapped Children.
7. Concurred with the recommendation of the Report of the Division on Rehabilitation that there be no change in the present policy of providing reimbursement for psychological services only when done under the supervision of and billed for by a physician. The House also approved the sponsorship of a conference to inform county societies of funds for ongoing programs in the fields of physical, speech, occupational, and hearing therapy.
8. Concurred in the recommendation of the Division on School Health that an adaptive physical education form be devised to permit the physician to recommend special types of physical education for students not able to take current courses.
9. Accepted the Report of the Division of Visual and Hearing Defects and concurred with the recommendation that these be separated into two Divisions —one on Ear, Nose and Throat and the other on Vision. The House also approved plans for revising the form for vision screening programs and the plans for conducting instruction courses for audiometric technicians.
10. Adopted the Report of the Division on Nervous and Mental Diseases and encouraged physicians to become involved in mental health program planning as well as program direction in their respective communities. Additionally, certain basic factors were stressed as essential considerations in the event the Mental Health Advisory Committee is terminated and another agency is developed or designated to fulfill the original concepts of the Advisory Commitee.

BEAUMONT MEMORIAL LECTURE. Dr. F. S. Simeone (left) of Cleveland, Ohio, was presented the William Beaumant Memorial Lecture Award fallowing presentation of his paper entitled "Small Bowel Obstruction." Dr. L. C. Pomainville (right) of Wisconsin Rapids made the presentation on behalf af the Charitable, Educational and Scientific Foundation of the State Medical Society which spansors the lecture.

ELVEHJEM MEMORIAL LECTURE. Dr. Jeremiah Stamler af Chicaga received the Elvehjem award far his lecture entitled "Diet and Other Factors in the Treatment of Atherasclerosis."

SCIENTIFIC LECTURERS. More than 1,300 physicians at the annual meeting had an opportunity to hear and participate in 86 scientific discussians and lectures during the three-day program. A tatal registratian caunt was set at 2,558, including 1,360 physicians, 72 physician guests, 230 interns-residents-seniar-juniar-medical students, 440 exhibit representatives, and 456 other guests such as certified nurses and wives of physicians.

VIETNAM VOLUNTEERS HONORED. The House of Delegates honored seven Wisconsin physicians for volunteer services to civilians in South Vietnam. Six of them are shown above, left to right: Drs. Thomas P. Chisholm of Arcadia, Victor S. Falk, Jr. of Edgerton, William B. Gallagher of La Crosse, Samuel B. Harper of Madison, Reynold M. Nesemann of Kewaunee, and Joseph P. Springer of Durand. Dr. Charles E. Hopkins of Madison was unable to attend the recognition event. Dr. L. O. Simenstad of Osceola, AMA trustee, made the presentation.

HOUSE OF DELEGATES PARTICIPANTS. Appearing before the extraordinary session of the House of Delegates were the following (left to right): Attorney Frank Ross, Jr., representing the Wisconsin Association of Professions; Dr. Peter L. Eichmon of Madison, dean of the University of Wisconsin Medical School; Dr. John S. Hirschboeck of Milwaukee, coordinator of the Wisconsin Regional Medical Program; Miss Alice Budny of Milwaukee, representing the Wisconsin State Medical Assistants Society; Dr. R. E. Callan of Milwaukee, speaker of the House; Dr. F. E. Drew of Milwaukee, president of the State Medical Society; Dr. E. H. Jorris of Madison, state health officer; Dr. Gerald A. Kerrigan of Milwaukee, dean of the Marquette University School of Medicine; and Dr. T. W. Tormey, Jr. of Madison, secretary of the State Board of Medical Examiners.

REFERENCE COMMITTEE ON REPORTS OF STANDING COMMITTEES

The House, on the basis of reports submitted by Standing Committees:

1. Accepted the Report of the Commission on Scientific Medicine and encouraged the Commission to set up a series of prematurity institutes.
2. Considered the Report of the Committee on Occupational Health and recommended that the Committee publicize in the WISCONSIN MEDICAL JOURNAL the availability and nature of the contents of the "Occupational Health Guide."
3. Adopted the recommendation changing the name of the Commission on Public Relations and Communications to the Commission on Health Information.
4. Reviewed the Report of the Commission on Hospital Relations and Medical Education and recommended that the Commission and the Division on Safe Transportation review the areas in which standards must be developed under the new highway safety act and report guidelines for implementation to the House at its next session. In addition,

ELECTIONS

Dr. George Behnke of Kaukauna was elected speaker of the House of Delegates; Dr. Theodore Nereim of Madison, vice-speaker. Elected new councilors: Drs. Jerry McRoberts of Sheboygan; Howard G. Bayley, Beaver Dam; and James M. Sullivan, Milwaukee. Reelected councilors: Drs. E. J. Nordby, Madison; H. W. Carey, Lancaster; James Sisk, Fond du Lac; and W. J. Egan, Milwaukee.

WINNERS OF RESIDENT-INTERN PROGRAM. Dr. Victor S. Falk, Jr. (right) of Edgerton presented $100 checks to the two winners of the resident-intern lecture program during the scientific portion of the annual meeting. The winners are Dr. James F. Romer (center) of Milwaukee, a resident in surgery at Marquette University School of Medicine; and Dr. Johan Mathison (left) of Milwaukee, a general resident at Milwaukee County Hospital. Doctor Romer received the Harry Beckman Award for his paper on "Experiences with Ex Vivo Perfusion of Cadaveric Human Livers." Doctor Mathison received the William Middleton Award for his paper on "Bioassay Technique for Diagnosis of Ulcerogenic Tumors." Doctor Folk was chairman of the judging committee.

the House concurred with the suggestion of the Commission that nurses, not presently active in the profession, take refresher courses and return to the profession of nursing on some basis.

5. Adopted the Report of the Commission on Public Policy and went on record opposing Assembly Bill 458 which would provide that an osteopath shall not be denied staff privileges solely because he is an osteopath. This bill could shift the burden of explanation from the applicant to the hospital and the medical staff which has the duty to pass on credentials.

The Reference Committee also considered the Supplementary Report and recommended that the Society continue its previously adopted policy which is aimed at assuring that in any reorganization of state government, the State Board of Health will retain essential autonomy so as to best serve the health interests of the entire public. The House concurred with this recommendation. It requested the Council to continue studying the proposed changes in abortion laws.

In the area of health insurance legislation, the House opposed a proposal which would put WPS and all other prepayment sickness care plans under the same type of regulation that the commercial companies face and hence throttle the experimental approach of the Blue plans.

6. Reviewed the Informational Report of the Executive Committee of the Board of Trustees of the Charitable, Educational and Scientific Foundation and commended the Foundation for its successful programs and projects which have greatly aided and encouraged the art and science of medicine.

REFERENCE COMMITTEE ON RESOLUTIONS AND AMENDMENTS TO THE BYLAWS

The House, on the basis of Resolutions and Reports, took the following actions:

1. Approved revision of Chapter VII, Section 5 of the Bylaws dealing with the Committee on Grievances. The following wording was adopted:

"The Committee on Grievances is empowered to receive complaints concerning individual physicians or groups of physicians, and initiate investigations under standing rules which it may establish. It may review decisions of local grievance or arbitration committees on appeal therefrom, but nothing in this section shall be construed as inconsistent with the provisions of Chapter VI relating to responsibilities of the Council.

"It shall be the purpose of the committee to endeavor to effect

RECEIVING LINE AT PRESIDENTS RECEPTION. The distinguished group (left to right): Dr. F. E. Drew of Milwaukee, outgoing president of the State Medical Society; Governor and Mrs. Warren P. Knowles of Madison; Dr. and Mrs. Harold J. Kief of Fond du Lac, incoming president of the State Medical Society; Dr. and Mrs. James C. Fox of La Crosse, chairman of the Council; Dr. and Mrs. Donald M. Britton of Madison, incoming president of the Woman's Auxiliary to the SMS; and Dr. and Mrs. David A. Hammes of Green Bay, outgoing president of the Woman's Auxiliary.

an equitable adjustment or understanding, and to resolve such differences between physicians, or between physician and patient or other complainant.

"The efforts of the committee may be extended into areas of interprofessional conduct, the development of appropriate codes of interprofessional relations, and its initial responsibility shall be to the Council of the State Medical Society. It shall consist of nine members appointed for terms of three years, one-third of such terms to expire annually.

"Consistent with the special purposes of this committee, all committee records and files pertaining to such matters shall be treated as confidential, shall not be open to inspection by other persons, shall not be released for any purpose and shall not be subject to subpoena."

2. Adopted the Report of the Division on Safe Transportation and recommended the Division be enlarged if necssary to consider boat traffic as well as other modes of transportation. The House also adopted *Resolution A* which reads:

"*Resolved*, That the Division on Safe Transportation of the Commission on State Departments be requested to promulgate adequate physical standards to be applied in the certification of school bus drivers, and their adoption by the proper state regulatory authorities be advised."

3. Deferred action on *Resolution B* introduced by the Section on Urology which called for a position favoring voluntary nontherapeutic vasectomy. Action was deferred since a study on the current law is in progress. The State Board of Medical Examiners has renewed its request for an opinion on this subject from the Attorney General.
4. Decided that the Report on Osteopathy forwarded by the Council in its supplementary report was preferable to *Resolution C* which would have called for a new committee to further investigate educational qualifications of osteopaths so that local hospitals could accept or reject applications on a more realistic basis.

The Report on Osteopathy, which was forwarded by the Council, contained the following recommendations:

(a) Through cooperation with the State Board of Health there has been a 16 year study of maternal deaths in the high purpose of doing everything possible to engage in postgraduate training and in preventive practices that would hold such deaths to an irreducible minimum. In negotiations with osteopaths it was suggested that their osteopathic hospitals submit to the same study as conducted of those institutions staffed by doctors of medicine. No commitment was offered by the osteopaths, no such study has yet been made, and it is urged that the several osteopathic hospitals in the state immediately offer to participate in such studies and to communicate their willingness to do so to the State Board of Health which licenses them.

(b) Information concerning the academic training, and more particularly such training as may have followed formal educational procedures of osteopathic practice in Wisconsin, is woefully weak in official files. During negotiation osteopaths were urged to provide the State Medical Society with this detailed information so that it could be made available upon appropriate inquiry by hospitals and by others. The osteopaths have not cooperated with this suggestion. At this point it seems highly imperative that their biographical and professional profiles data be made available. It is hoped that the State Board of Medical Examiners will take immediate steps to make certain that this is done so that information can be released by it with official status.

(c) All members of the Wisconsin Osteopathic Association have been and are now being invited to scientific courses, including those sponsored by official bodies of the state and by the State Medical Society, although this year the Association declined any invitation to the scientific sessions at the Annual Meeting of the State Medical Society since their meeting was scheduled on conflicting dates. The State Medical Society, whose Annual Meeting dates have been established for the next three years, urges the Wisconsin Osteopathic Association to change its annual meeting date so that this conflict will not exist in the future.

(d) One of the basic tenets of the doctor of medicine is that he will give no support and lend no credence to the practice of quackery, and Wisconsin osteopaths are urged to make a similar formal announcement as a tenet of the members of their association. This should be restated as often as necessary, as in the case of those of doctors of medicine.

(e) The Council should state its intent to examine into the professional, ethical and legal implications of formal associations between doctors of medicine and doctors of osteopathy to the same extent that there may be such association between doctors of medicine and surgery. This involves such matters as employment, limited or full partnership, and similar considerations.

COUNCIL AWARD. The man who founded and now heads Project HOPE, Dr. William B. Walsh (left), was given the highest Society award by Dr. James C. Fox of La Crosse, chairman of the Council, who said that Doctor Walsh's leadership and "magnificent mission . . . kindled by devotion to the common good, has set an example for all the world." Doctor Walsh of Washington, D. C. founded Project HOPE in 1958. He obtained a 15,000-ton Navy ship and converted it into the 235-bed hospital ship, SS HOPE. The vessel has made five voyages to bring medical aid and training to underdeveloped countries. Several Wisconsin physicians have volunteered their services.

5. *Resolution D* was rejected on the basis that it was possibly unwise to propose specific legislation on utilization review committees inasmuch as physicians are ordinarily without legal liability when they serve on hospital staff committees and conduct their duties in good faith.
6. *Resolution E* related to Title XVIII of the Social Security Act and the House supported this proposed amendment to the Social Security Act which would permit payments without assignments for medical care of a patient.
7. *Resolution F* was adopted by the House and commends Congressman Zablocki for his efforts in introducing a bill (H.R. 6561) to permit an individual to be paid for charges by a physician under the supplementary benefits program prior to the individual's own payment for the charges involved.

(NOTE: The House in adopting Resolutions E and F also adopted the following statement—". . . safeguards should be taken for payment of the individual physician in a form that is acceptable to him after more experience is gained under the program.")

MEAD JOHNSON AESCULAPIAN AWARD. Dr. John R. Cafaro of St. Joseph's Hospital, Milwaukee, won the Mead Johnson Aesculapian Award for having the best scientific exhibit in the nonsurgical group. His exhibit was entitled "Renin-Angiotensin System."

PRESIDENT-ELECT W. D. JAMES, OCONOMOWOC

Dr. William D. James of Oconomowoc, a general practitioner, became president-elect of the State Medical Society at its annual meeting during the final session of the House of Delegates Wednesday afternoon, May 10.

Born in Evanston, Ill., Doctor James attended Lawrence College and earned his MD degree from the University of Wisconsin Medical School in 1935. His internship and residency training were taken at Milwaukee County Hospital, 1935–1937.

Doctor James began his practice in Oconomowoc in 1937, then served in the armed forces from March 1941 to 1946. In November 1966, he retired from the active reserve as a colonel after twenty-four and a half years of service. Following active duty in 1946, he returned to practice in Oconomowoc where he continues to practice.

Active in Society affairs, Doctor James is a past president of the Waukesha County Medical Society and was a member of the Council from 1954 until his recent election. As a member of the Council he has served on various committees, most recently the finance committee, as well as the executive committee. He has been particularly interested and active in the Society's health insurance program.

8. *Resolution G* petitions the United States to issue a commemorative postage stamp honoring Dr. William Beaumont on the 150th Anniversary of his examination of Alexis St. Martin and was passed.
9. *Resolution H* which calls for continued opposition to legislation which would put artificial restraints on sources of health service (Hart Bill S. 260, 90th Congress) was adopted.
10. *Resolution I* states that the State Medical Society favors that all possible steps be taken to preserve the Disability Insurance Program of the AMA at the present level of benefits and premiums. This resolution was adopted.
11. *Resolution J* pays tribute to George B. Larson, a former employee of the State Medical Society, who is retiring this

year as a member of the American Medical Association executive staff.

12. *Resolution K*, which was adopted by the House, expresses appreciation to Roy T. Ragatz for the dedicated service that he rendered to the State Medical Society during his more than 23 years of association with the Society.
13. Accepted a series of resolutions submitted by the Council and previously adopted by the Joint Committee on Health Problems in Education of the National Education Association and the American Medical Association. These resolutions were referred to the Division on School Health.
14. Accepted the Report of the Council as a whole and recommended adoption of the addition of a Reference Committee on Finances to Chapter III, Section 4 of the Bylaws.

REFERENCE COMMITTEE ON FINANCES

The House of Delegates, on the basis of the Treasurer's Report, the Report of the Commission on Medical Care Plans, and financial statements:

1. Accepted the Report of the Commission on Medical Care Plans and its supplementary report. The House noted with favor that affirmative steps are being taken in the sale of diagnostic and other medical outpatient benefits by health insurance carriers.
2. Accepted the financial statements of the Society and its Divisions.
3. Referred for further consideration by the Council a recommendation that a per diem stipend be provided for the President of the Society during his year in office.
4. After reviewing activities and financial statements, adopted the recommendation that dues continue in the same amount as at present for 1968.

SPECIAL MERIT AWARDS TO SCIENTIFIC EXHIBITORS

Dr. Richard D. Sautter, Marshfield Clinic Foundation, Marshfield, *Urokinase in the Treatment of Acute Pulmonary Thromboembolism.*

Dr. J. A. Klieger, St. Joseph's Hospital, Milwaukee, *Aminocentesis and Intrauterine Transfusion.*

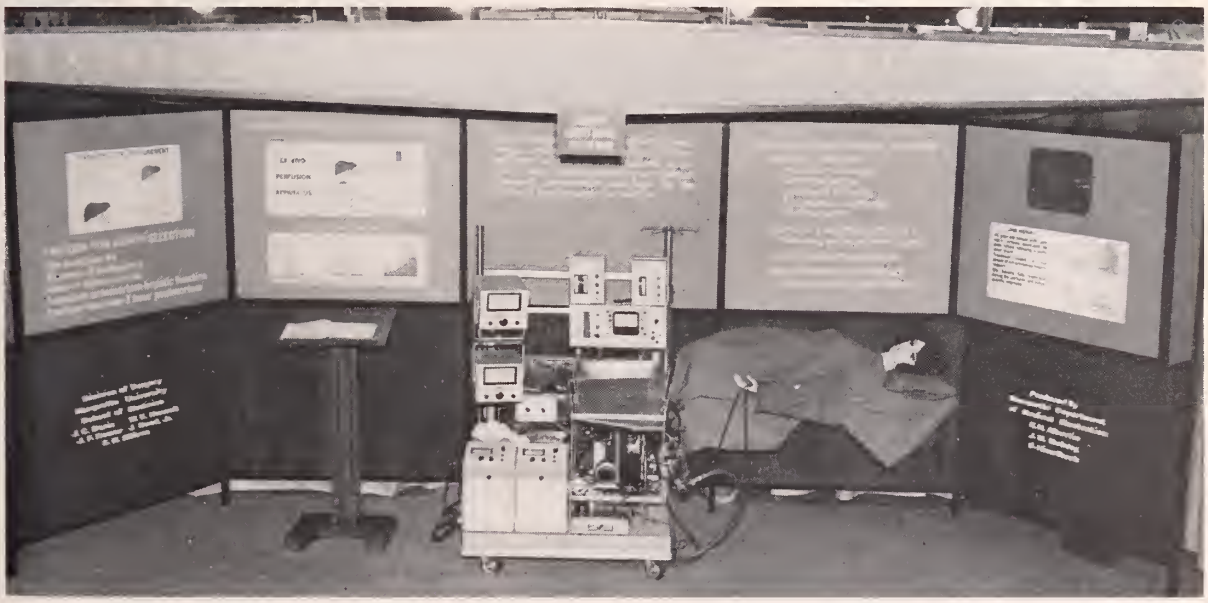
Dr. William H. Frackelton, Columbia Hospital, Milwaukee, *Finger Ring Avulsion Injuries.*

Dr. Palmer Kundert, Department of Surgery, University of Wisconsin Medical School, Madison, *The Sleeve Urethroplasty.*

DISTINGUISHED SERVICE AWARD. Dr. Otto A. Mortensen (right) of Madison, associate dean of the University of Wisconsin Medical School, received the Distinguished Service Award from Dr. John K. Curtis (left) of Madison, outgoing chairman of the Commission on Scientific Medicine. The honor was bestowed on Doctor Mortensen "for his outstanding contributions to the science and art of medicine in the teaching of anatomy to medical students at the University . . . since 1930, and for his willingness to assume important administrative duties in addition to his teaching assignments."

Dr. William G. Richards, Clinical Pathology Laboratory, Beaver Dam, *The Enzymatic Biopsy.*

Dr. Edwin L. Bemis, Department of Pathology and Laboratory Medicine, Deaconess Hospital, Milwaukee, *Aspirin and Bleeding: The Influence of Acetylsalicylic Acid on Hemostasis.*



GUNDERSEN TEACHING AWARD. The Gundersen Teaching Award, presented annually for the best teaching exhibit in surgery, was given to Dr. Joseph C. Darin of the Division of Surgery, Marquette University School of Medicine, Milwaukee, for his exhibit entitled "Extracorporeal Hepatic Support System." The award is given by the State Medical Society to honor Dr. Gunnar Gundersen of La Crosse, former president of the American Medical Association and the State Medical Society of Wisconsin.

FIRST AWARD in oil and Popularity Award: "A View Along the Arno" by Dr. A. M. Gottlieb of Madison.

PHOTOGRAPHY WINNERS

BEST IN SHOW

Dr. M. G. Peterson, "Winter Sunrise—Crawfish River"

COLOR

Medicine

1. Dr. J. Martin Johnson, "Infected Ear"
2. Dr. J. Martin Johnson, series, "Contaminated Laceration of Face and Scalp Through Ear"
3. Dr. E. W. Wits, "Extensive Ulceration of Leg"

Honorable mention: Dr. E. W. Wits, "Fractured Clavicle X-Ray"

Travel

1. Dr. K. A. Seifert, "Heavenly Splendor"
2. Dr. M. B. Llewellyn, "Trick Falls"
3. Dr. E. W. Wits, "Mavi—The Valley Island"

Honorable mention: Dr. C. A. Ferrou

Animals

1. Dr. E. W. Wits, "Brown Beauty"
2. Dr. N. A. Eidsmoe, "Red Squirrel"

People

1. Dr. E. W. Wits, "In the Pool"
2. Dr. Alfred Jerofke
3. Dr. K. A. Seifert, "Fishing Pals"

FIRST AWARD in watercolor: "Winter Scene" by Dr. George L. Lucas of Madison.

Honorable mention: Dr. E. W. Wits, "Good Morning, Doctor"

Pictorial

1. Dr. M. G. Peterson, "Winter Sunrise—Crawfish River"
2. Dr. M. G. Peterson, "February Reflections"
3. Dr. M. G. Peterson, "Sunset at Shimabara—Japan"

Honorable mention: Dr. K. A. Seifert, "Vermont Tranquility"

BLACK AND WHITE

People

1. Dr. R. C. Hickey, "Sisters of Serville"
2. Dr. Paul Meis, "Snowbird"

Pictorial

1. Dr. Paul Meis, "Wounded Christ"
2. Dr. Joseph L. Teresi, "Life"
3. Dr. Joseph L. Teresi, "Lyrical Strings"

Honorable mention: Dr. Joseph L. Teresi, "Atomic Attitudes"

MEDICAL ART SALON WINNERS

FIRST AWARD

Dr. A. M. Gottlieb, Madison, *A View Along the Arno*, oil.

Dr. George L. Lucas, Madison, *Winter Scene*, watercolor.

Dr. Werner A. Hauschild, Kenosha, *Father*, sculpture.

SECOND AWARD

Dr. A. M. Gottlieb, Madison, *Enigma*, oil.

Dr. A. M. Gottlieb, Madison, *Ballet Fantasy*, watercolor.

Dr. Hania W. Ris, Madison, *The Tankanese*, sculpture.

THIRD AWARD

Dr. Guy W. Carlson, Appleton, *Desert Scene*, oil.

Dr. John Erbes, Milwaukee, *Door County*, watercolor.

Dr. Bruno J. Peters, Milwaukee, *Cinder Pot*, *Black Engboe*, and *Mexico*, pottery.

Mrs. M. Alex Krembs, Milwaukee, *Vase*, *Tea Set*, and *Creamer*, pottery.

POPULARITY AWARD

Dr. A. M. Gottlieb, Madison, *A View Along the Arno*, oil.

NEW OFFICERS FOR WOMAN'S AUXILIARY

New officers of the Woman's Auxiliary to the State Medical Society are: president, Mrs. Donald M. Britton, Madison; president-elect, Mrs. James Sargent, Milwaukee; vice-president, Mrs. William Smollen, Racine; recording secretary, Mrs. William Janssen, Mequon; corresponding secretary, Mrs. C. W. Stoops, Madison; treasurer, Mrs. T. W. Tormey, Madison; and immediate past president, Mrs. David Hammes, Green Bay.

WOMAN'S AUXILIARY. Mrs. T. W. Tormey of Madison, treasurer; Mrs. John J. Satory of La Crosse, a past president; the Governor's wife, Mrs. Warren P. Knowles of Madison, guest of honor; and Mrs. Donald M. Britton of Madison, president.

DONATIONS GIVEN BY WOMAN'S AUXILIARY

Significant donations by the Auxiliary were announced at the annual meeting as follows:

Vietnamese Student Aid Project of WA to AMA: $25; Museum of Medical Progress, $200; Guaranteed Loan Fund of AMA–ERF: $200; Biomedical Research of AMA–ERF: $200; Nineteenth century silver coffee urn for the Executive Mansion: $300 to Mrs. Warren P. Knowles; and Scholarships: $800 (3 in the field of nursing and 1 in medical technology, $200 each).

Fifty-Year Club Members Honored

MEMBERS OF THE FIFTY-YEAR CLUB. Standing (left to right): Drs. Albert R. Tormey of Madison, Edmund A. W. Schalter of Milwaukee, Leo A. Hoffmann of Campbellsport, Clarence H. Boren of Marinette, Roland S. Cron of Milwaukee, Russell A. Oldfield of Eagle River, Edward F. Mielke of Appleton, and J. Arthur Riegel of St. Croix Falls; seated: Sarkis H. Kosh of Cudahy, Timothy J. Howard of Milwaukee, Michael Kosak of Milwaukee, B. H. Schlomovitz of Milwaukee, and Herman A. Heise of Milwaukee. The other member, Dr. Karl H. Doege of Marshfield, was unable to attend.

BRIEF BIOGRAPHIES

CLARENCE H. BOREN, M.D.: Marinette, Wisconsin
Doctor Boren was born on October 28, 1892, in Marinette, Wisconsin. He graduated from Northwestern University Medical School in 1917 and served his internship at Michael Reese Hospital, Chicago, in 1917–1918. He served in World War I. In 1919, with his brother, Dr. J. W. Boren, a group practice was started in Marinette. Doctor Boren, who specializes in Surgery, remains in active practice with the Boren Clinic, a six-doctor group. Doctor Boren was honored by the Marinette–Florence County Medical Society in November 1964 for his 45 years of community medical service. In May 1966, the Marinette Chamber of Commerce awarded him the "Man of the Year" plaque for civic service. Doctor and Mrs. Boren have two sons who are physicians. A grandson, Clark Boren, is a pre-medical student.

ROLAND S. CRON, M.D.: Milwaukee, Wisconsin
Doctor Cron was born on May 19, 1892, in Manistee, Michigan. He graduated from the University of Michigan Medical School in 1917 and after serving in World War I he joined the faculty of his Alma Mater and has practiced in Milwaukee since 1923. Doctor Cron is a member of many city, state and national Obstetrics and Gynecology societies. He was formerly professor and chairman of the Department of Obstetrics and Gynecology at Marquette University School of Medicine and chief of Obstetrics and Gynecology at Milwaukee County Hospital. Doctor and Mrs. Cron reside in Milwaukee.

KARL H. DOEGE, M.D.: Marshfield, Wisconsin
Doctor Doege was born in Marshfield, Wisconsin on August 14, 1892. He received his bachelor of science degree from the University of Wisconsin prior to entering Johns Hopkins University School

K. H. Doege, M.D.

AN HONOR OF FAITHFUL SERVICE

Annually the State Medical Society of Wisconsin pays its respect to members who have served their profession and patients for 50 years. It is an honor which is expressed by fellow practitioners on behalf of the communities and patients who have been served by physicians of experience and integrity. On these pages are the names, pictures, and short biographical data of those physicians honored by the Councilors, Officers, and Past Presidents of the Society at the 126th Annual Meeting of the State Medical Society of Wisconsin, held in Milwaukee, May 9–11, 1967.

f Medicine, from which he graduated in 1917. After serving in Vorld War I he located in Marshfield, where he served on the Staffs f the Marshfield Clinic and St. Joseph's Hospital. Doctor Doege as been a fellow of the American College of Physicians since 1931 nd in 1937 he was certified by the American Board of Internal Iedicine. Doctor Doege was Medical Editor of the *Wisconsin Medi-al Journal* from 1939 to 1948. In 1948 he was elected president of he State Medical Society. He has been a member of the Society's Commission on Medical Care Plans for 15 years. His son, Paul, is irector of the Blue Shield Plan in Minnesota.

IERMAN A. HEISE, M.D.: Milwaukee, Wisconsin
Doctor Heise was born on October 20, 1891, in Milwaukee, Wiscon-in. He graduated from Rush Medical College in Chicago in 1917 nd served in World War I. He was certified by the American Board f Internal Medicine and specialized in the practice of Allergies. He s widely recognized for his research in the testing of alcoholic con-ent in a person, and for his pioneering efforts in highway safety. Doctor and Mrs. Heise reside in Milwaukee and have two children.

EO A. HOFFMANN, M.D.: Campbellsport, Wisconsin
Doctor Hoffmann was born in Campbellsport, Wisconsin on October , 1893. He graduated from the Marquette University School of Iedicine in 1917 and served in World War I in 1918. After the ar he returned to Campbellsport to begin his general practice. Ie is also a former president of the Fond du Lac County Medical ociety.

IMOTHY J. HOWARD, M.D.: Milwaukee, Wisconsin
Doctor Howard was born on January 15, 1894, in Milwaukee, Wis-onsin. He graduated from the Marquette University School of Iedicine in 1917 and interned at Milwaukee County General Hos-ital in 1917–1918. He served in World War I and returned to Iilwaukee to specialize in the practice of Internal Medicine. He as an assistant professor of Medicine at Marquette and a former resident of The Medical Society of Milwaukee County, a former ember of the Milwaukee Academy of Medicine, a former councilor the State Medical Society, and a former president of the Mar-uette University Alumni Association.

ICHAEL KASAK, M.D.: Milwaukee, Wisconsin
Doctor Kasak was born May 13, 1884, in Latvia but educated above igh school in the United States. He received his B.S. degree from he University of Wisconsin in 1915, and his M.D. degree from Vashington University Medical School, St. Louis, Missouri, in 1917. After graduation he specialized in Neurology and Psychiatry at Vashington and Harvard universities and the University of Berlin Germany. Doctor Kasak is a diplomate of the American Board f Psychiatry and Neurology. He has resided in the United States ince 1906 except for three years when he returned to Latvia to help the organization of the Neurological Department of the newly ounded University of Latvia in Riga, 1922–1925. A member of any learned societies, he is a past president of the Milwaukee Neu-opsychiatric Society. He has had numerous scientific papers pub-shed and been a frequent speaker at scientific meetings. He was Iedical Director of the Milwaukee County Hospital for Mental Diseases until his retirement May 31, 1956; Emeritus Director and Clinical Professor of the Division of Psychiatry at Marquette Uni-ersity and special lecturer at Milwaukee Downer and Mount Iary Colleges. Doctor Kasak continues to be active as a court-ppointed psychiatrist. Doctor and Mrs. Kasak have one married aughter who with her husband are joining us in honoring Doctor Kasak—Mr. and Mrs. James E. Detienne.

ARKIS H. KASH, M.D.: Cudahy, Wisconsin
Doctor Kash was born in Armenia on September 6, 1894. He was raduated from the University of Michigan Medical School in 1917. Ie was honored at a testimonial dinner in 1960 for being Cudahy's ealth commissioner and school physician for 27 years. Doctor and Irs. Kash reside in Cudahy.

EDWARD F. MIELKE, M.D.: Appleton, Wisconsin
Doctor Mielke was born December 3, 1892, in Shawano, Wisconsin He graduated from the University of Wisconsin in 1915 and from Rush Medical College of Chicago in 1917. He served in World War I for one year. He took his internship at Cook County Hospital in Chicago. He was an assistant to Dr. Albert Ochsner at Augustana Hospital for one year. He began his practice in Appleton in 1921 with special interest in Surgery. He was associated with the late Dr. E. L. Bolton for 35 years. Doctor Mielke was an alternate delegate to the State Medical Society for one year. He has been president of the Outagamie County Medical Society, first Chief-of-Staff of Appleton Memorial Hospital, Senior Federal Aviation Medical Examiner for many years, and a licentiate of the National Board of Medical Examiners. He now practices with his son, Dr. John Mielke, a cardiologist. Dr. and Mrs. Mielke have four children.

RUSSELL A. OLDFIELD, M.D.: Eagle River, Wisconsin
Doctor Oldfield was born February 14, 1892 in Bay City, Michigan He graduated from the University of Michigan School of Medicine in 1917 and served on the surgical service there until entering the Army. He served as a physician with the Marines in World War I Doctor Oldfield has been practicing in Eagle River since 1925. Before his semi-retirement he was a member of the Wisconsin Academy of General Practice.

J. ARTHUR RIEGEL, M.D.: St. Croix Falls, Wisconsin
Doctor Riegel was born in Tracy, Minnesota on March 25, 1889 He graduated from the University of Minnesota Medical School in 1917 and served with the Navy in World War I. After World War I he set up his practice in St. Croix Falls with special interest in Surgery. He is a former director of the St. Croix Falls Hospital and past president of Polk County Medical Society.

BENJAMIN H. SCHLOMOVITZ, M.D.: Milwaukee, Wisconsin
Doctor Schlomovitz was born on May 18, 1889, in Milwaukee, Wisconsin. He graduated from Rush Medical College in 1917 and did teaching and research work at Rush, Iowa State Medical College University of Wisconsin and Marquette medical schools, chiefly as Professor of Physiology. Doctor Schlomovitz served as a civilian in Chemical Warfare Service in World War I. After the war he started his practice in Internal Medicine with special interest in Pathology. He was formerly a consultant and director of the laboratory at the Veterans Administration Hospital for 20 years at Wood, Wisconsin. Doctor Schlomovitz has two children.

EDMUND A. W. SCHOLTER, M.D.: Milwaukee, Wisconsin
Doctor Scholter was born on May 6, 1887 in Detroit, Michigan. He graduated from Marquette University School of Medicine in 1917 and was licensed for practice in Wisconsin and Illinois. He is a certified surgeon and a member of the Industrial Medical Association. From 1921 to 1929 he was a full-time professor of Anatomy at Marquette. He was president of the American Medical Society in Vienna, Austria, in 1930. He is a veteran of World War I.

ALBERT R. TORMEY, M.D.: Madison, Wisconsin
Doctor Tormey was born on February 24, 1891 in Madison, Wisconsin. He received his Bachelor of Arts degree in 1914 from the University of Wisconsin and graduated from Washington University Medical School in St. Louis in 1917. Doctor Tormey took his internship at Barnes Hospital in St. Louis and Augustana Hospital in Chicago. Doctor Tormey, while he attended the University of Wisconsin, was known as one of the best half-backs in football. He served as president of the national W. club in 1949–1950 and also was an alumni representative on the University athletic board. He served in World War I as a medical officer in the A.E.F. in France. In 1925 he was elected to membership in the American College of Surgeons. Doctor Tormey is a past president of the Dane County Medical Society, and was a delegate to the State Medical Society several years. He is currently vice-president and medical director of National Guardian Life Insurance Co. He has three daughters and one son, who is a physician in Texas.

NEWS OF WISCONSIN PHYSICIANS

Dr. Quick Honored for Blood Research

Dr. Armand J. Quick, Milwaukee, a widely known researcher in blood coagulation, has been selected by the James F. Mitchell Foundation for Medical Education and Research to be a recipient of its annual international award for heart and vascular research.

Dr. Zeit Receives Citation

Walter Zeit, Ph.D., Milwaukee, was honored recently at the annual Pere Marquette dinner with a citation and check for his teaching excellence. Doctor Zeit is chairman of the department of anatomy and associate dean of the medical school. Doctor Zeit earned his degrees at Marquette and has been with the medical school since 1921 when he was a student assistant in anatomy.

Dr. Borge Becomes Associated With Mauston Clinic

Dr. Alf Borge, a medical missionary in Madagascar for nine years, will become associated with the Mauston Clinic in July. Doctor Borge received his education at the University of Wisconsin in Madison.

Dr. McRoberts to Head U. S. Railway Surgeons

Dr. Jerry McRoberts, Sheboygan, recently was installed as president of the American Association of Railway Surgeons at its annual meeting held in Chicago. Doctor McRoberts graduated from the University of Saskatchewan, Canada, and earned his medical degree at McGill University in Montreal where he served as an instructor in pathology.

Manitowoc Physician Guest Speaker

Dr. Thomas Arnold, Manitowoc obstetrician and gynecologist, recently was the guest speaker at the Manitowoc Technical Institute.

Dr. Campbell Honored

Dr. Ralph E. Campbell, who will retire as professor of gynecology and obstetrics at the University of Wisconsin Medical School on July 1, was honored at a dinner May 13. *Dr. Otto Mortensen*, professor of anatomy and associate dean of the Medical School, was the toastmaster for the evening. Doctor Campbell's associates in the medical profession and his friends had an opportunity to express appreciation for his achievements in the past and wish him well for the future.

Dr. Puestow Speaks on Health

Dr. Robert Puestow, Manitowoc, recently gave a speech on "Psychosomatic Illness" at the Manitowoc Technical Institute. Doctor Puestow is associated with the Manitowoc Clinic.

Nursing League Hears Dr. Middleton

Dr. William S. Middleton, emeritus dean of the University of Wisconsin Medical School, recently spoke before the Wisconsin League for Nursing in Madison. In his address, "The Dynamic Health Field," Doctor Middleton said, "that the scientific revolution will pale the industrial revolution of the last century and the health team consisting of doctors, nurses, physical therapists, social workers, spiritual advisor, and clinical psychologists must work together."

Dr. Hopkins Speaks to Nursing Association

Dr. Charles E. Hopkins, Madison, recently spoke on "Volunteer Medicine in Vietnam" at the annual banquet of the Madison District Nurses Association and the Madison League for Nursing. Doctor Hopkins also showed illustrated slides of his experiences in Vietnam.

Dr. Ansfield Featured in Paper

Dr. Fred J. Ansfield, Madison, has been the subject of a series of articles on cancer research recently in the MILWAUKEE SENTINEL. Doctor Ansfield is a clinical oncologist and chemotherapist in cancer research in Madison.

Dr. Rammer, Jr. Elected to AAGP

Dr. Martin A. Rammer, Jr., Sheboygan, recently was elected to active membership in the American Academy of General Practice, a national association of 29,000 family doctors.

Dr. Kronquist Elected to Pediatrics Group

Dr. Gordon E. Kronquist, Janesville, a member of the Pember-Nuzum Clinic, was recently elected to fellowship in the American Academy of Pediatrics in San Francisco.

Doctors Participate in Heart Forum

Drs. Robert Beilman, Paul Davidson, Edgar Gordon, William Rock, and *Arvin Weinstein*, all from Madison, recently answered questions on heart disease at the Dane County Fairgrounds Youth Building. Dr. Louis N. Katz, Chicago, and *Dr. Ovid Meyer*, chairman of the Dane County unit of the American Heart Association and a professor of medicine at the University of Wisconsin, also participated.

Medical Personnel Aid Tornado Victims

Dr. Dean Smith, a Belvidere native, along with nine doctors from Madison including *Drs. Kenneth Sachtjen, John Batson, Richard Botham, Milfred*

Physicians whose names appear in italics are members of the State Medical Society.

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PHYSICIAN NEWS *continued*

Cunningham, George Vogt, John McClung, Darwin Waters, David Noll, and *Larry H. Hogan* volunteered their services to aid the victims of the tornado which did extensive damage near Belvidere, Ill. They were accompanied by nurses and laboratory technicians from the Madison area. The medical help was diverted to Rockford because the most seriously injured in Belvidere were sent there.

Dr. Neupert Elected to Fairhaven Board

Dr. Carl N. Neupert, Madison, former Wisconsin state health officer, was recently elected to the board of directors of Fairhaven Corporation in Whitewater. Fairhaven is a retirement home for the elderly.

Dr. Weber Fellow in Forensic Science

Dr. George Weber, Kenosha, has been appointed a fellow of the American Academy of Forensic Science, it was announced recently at the Academy's meeting in Hawaii. Doctor Weber is on the staff of Kenosha Memorial Hospital and St. Catherine's Hospital. He graduated from the University of Indiana and took his specialization in psychiatry at Downey Veteran's Hospital.

Dr. Edwards Guest Speaker

Dr. W. C. Edwards, Richland Center, was the guest speaker at the dinner of the First Congregational Church Women's Fellowship. Doctor Edwards gave a lecture on the European trip he made in 1966 and illustrated the lecture with slides.

Dr. Weatherhogg Speaks at PTA Meeting

Dr. C. R. Weatherhogg, Madison, recently spoke on "Why Do Our Children Need Sex Education?" before the PTA meeting in Lake Mills. Doctor Weatherhogg has spoken widely on the subject for the past six years and is a member of the teaching clinical faculty at the University of Wisconsin Medical School.

Dr. Lindert Appointed

Dr. M. C. F. Lindert, Milwaukee, has been appointed vice-president and medical director for Association Life Insurance Co. in Milwaukee. He is an associate clinical professor of medicine at Marquette University School of Medicine and has been chief-of-staff of several hospitals in Milwaukee.

Dr. Goldstein Guest Speaker

Dr. David N. Goldstein, Kenosha, was the guest speaker at the annual Wisconsin Anti-Tuberculosis Association conference recently held in Milwaukee. Doctor Goldstein's topic was on "Kenosha's Tubercular Industrial Preventive Program." *Dr. Josef Preizler,* deputy director of Preventable Diseases of the State Board of Health, recommended that other communities follow Kenosha's initiative in originating and implementing progressive antitubercular programs.

Dr. Kochell New Associate

Dr. Richard L. Kochell, Janesville, recently became an associate of *Dr. Robert A. Holland* at Doctors' Park in the practice of obstetrics and gynecology. Doctor Kochell is a graduate of Purdue University and Indiana University School of Medicine. His internship and specialty training were at St. Vincent's Hospital, Indianapolis, Ind.

Dr. Currie Certified in Specialty Field

Dr. Robert E. Currie, Racine, has been certified in the specialty of anesthesiology by the American Board of Anesthesiology. Doctor Currie graduated from the University of Colorado School of Medicine and his specialty study was taken in Los Angeles.

Dr. Reed Guest Speaker

Dr. William H. Reed, Watertown, recently was the guest visiting expert on Watertown's third annual radio program on cancer, "Ask the Expert." He received his B.S. and M.D. degrees from Northwestern University and took his residency in surgery at Cook County Hospital, Chicago. Doctor Reed also participated along with *Dr. George D. Miller*, Oconomowoc, in a "Meet the Press" gathering before a group of students on the dangers of smoking and lung cancer.

Dr. Garner Speaks on Glaucoma

Dr. Lawrence L. Garner, assistant chief of the Outpatient Service at the Veterans Administration Center, Wood, has been presenting a series of lectures on Glaucoma in the Milwaukee area. Doctor Garner spoke to the medical and nursing staffs of the Wisconsin Telephone Company on "Glaucoma Screening in Industry," to the Wisconsin Society of Opticianry, Inc. on "Glaucoma," and he also presented a lecture to the Kiwanis Club of North Shore on "Glaucoma and Your Sight Expectancy."

Drs. Bugarin, Francisco Announce New Clinic

Dr. N. L. Bugarin announced recently that he is opening a new Family Clinic in Tomahawk. Joining him in the new offices to be completed about July 1, will be *Dr. O. M. Francisco.*

Dr. Karrmann Certified

Dr. Paul L. Karrmann, Jr., Manitowoc, recently was certified by the American Board of Obstetricians and Gynecologists. Doctor Karrmann received his bachelor of science degree at Marquette University and was graduated from the Marquette University School of Medicine. He served his internship at St. Mary's Hospital, and his residency in obstetrics and gynecology was taken at Milwaukee Hospital.

Dr. Opitz Guest Speaker

Dr. John M. Opitz, assistant professor of medical genetics and pediatrics at the University of Wisconsin, Madison, recently was the guest speaker at a dinner meeting of the Jefferson County Association for Retarded Children. Doctor Opitz spoke on some

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recent genetic discoveries in the field of mental retardation. Doctor Opitz has held postdoctoral fellowships at the University of Wisconsin and has done extensive research in genetics at both University of Iowa and the University of Wisconsin.

Dr. Weston to Assist Hospital Drive Unit

Dr. Frank L. Weston, Madison, will assist as vice-chairman in the drive for the Greater Madison Hospitals Expansion Campaign. The Campaign is seeking $3,500,000 in public subscriptions toward a $20,000,000 program of expansion and modernization of Madison General, St. Mary's, and Methodist hospitals and a portion toward an equipment fund for a new eastside hospital.

Dr. Harper Guest Speaker

Dr. Samuel B. Harper, Madison, recently gave an illustrated talk on his experience as a surgeon in Vietnam at the Ladies Day Out program sponsored by the Young Women's Christian Association.

Dr. Falk Aids Vietnamese

Two pieces of surgical equipment have been purchased and sent to Vietnam by *Dr. Victor S. Falk* from contributions he has received for the Vietnamese hospital where he was a volunteer with Project Vietnam. He also has sent one hundred dollars for canned milk to the orphanage next door to the hospital. Doctor Falk who spent two months in Vietnam last winter has given some 23 talks to groups on his experiences.

Doctor Chou, UW Scientist, Presents Paper

Initial evidence that a virus causes chronic polymyositis, a common human muscle disease, was advanced by a University of Wisconsin professor of pathology recently.

Dr. S. M. Chou, who divides his time between the UW Medical School and the Wisconsin Regional Primate Research Center, addressed the 19th annual meeting of the American Academy of Neurology. His major area of interest is experimental and human neuropathology.

"It is thought now," Doctor Chou stated, "that mitochondrial diseases are caused by a defect in structure or function of the mitochondria, a vital part in the metabolic processes of the cell, and that each one of the diseases classed under this grouping has a specific ultrastructural abnormality."

In his paper, Doctor Chou cited a single case of this disease in which electron micrographs of cell structure show several of the specific types of abnormal mitochondria, and also what appear to be virus particles in the nucleus and other parts of the cell.

With this preliminary evidence, he suggested that the changes might be nonspecific secondary alterations, and "the primary cause of this particular disease is due to a virus, probably a member of the common influenza group."

Doctor Chou said that should subsequent study establish this to be the case, it is possible immunization against the disease would be developed.

Dr. Heinen Presented Award

Dr. Robert D. Heinen, Oconto, has been selected by a 14-man national board of editors for inclusion in "Outstanding Young Men of America." Doctor Heinen graduated from the University of Wisconsin Medical School and served his internship and residency at the Gundersen Clinic and La Crosse Lutheran Hospital.

Dr. Carol E. Craig Serves in Vietnam

Dr. Carol E. Craig, director of the Health Service and college physician at Mount Holyoke College, has been selected by the American Medical Association as the second woman to go to Vietnam under the AMA Volunteer Physicians for Vietnam Program. Doctor Craig applied last October as a volunteer physician but her application was rejected because the program was not accepting women. Doctor Craig's application was finally approved last January. Doctor Craig received her medical degree from the University of Wisconsin and served her internship and residency in internal medicine at Youngstown Hospital, Ohio.

Doctors Urge Tetanus Shots

Dr. Louis C. Bernhardt and *Dr. Robert C. Hickey*, Madison, in a recent issue of the AMERICAN JOURNAL OF SURGERY, stated, "that tetanus . . . is still a threat and that mortality from untreated tetanus infections is between 90 and 100 per cent." Doctors Bernhardt and Hickey urged tetanus toxoid immunization for all persons, and care in maintaining protection with booster injections.

Doctors Hold Press Conference on Smoking

Drs. Robert Samp, Madison, *Ronald Karzel* and *Thomas Hansen*, Janesville, recently conducted a press conference of some 78 students from schools in Janesville, Beloit, Evansville, Milton, Fort Atkinson, and Jefferson on the hazards of smoking. The doctors urged the students not to begin the habit or to quit before it was too late. They explained how smoking affected the lungs and showed x-rays on cancer tumors. Doctor Samp stated, "that despite intensive warning campaigns more than half of all teenagers ignore the proved dangers to their health and become regular cigarette smokers by the time they are 18, even though lung cancer took 136 lives each day last year."

Dr. Morton Receives Masonic Honor

Dr. Homer H. Morton, Dodgeville, recently received a 50-year membership certificate from the Linden and Dodgeville Masonic Lodges. Doctor Mor-

ton started his medical practice in Cobb in 1908 after graduation from Marquette University. In 1928 he established another practice in Dodgeville as well as in Cobb, and then moved in 1932 to Dodgeville where he continued his practice until his retirement in 1962. Doctor Morton resides at St. Joseph's Hospital at the present time.

Psychiatry Lecture by Dr. Forster

Dr. Francis Forster, professor and chairman, Department of Neurology, UW Medical School, recently discussed "Conditioning in Epilepsy" on the Madison campus. The lecture was sponsored by the Department of Psychiatry, UW Medical School, and the Wisconsin Psychiatric Institute.

Medical School Expansion Vital, State Unit Says

Wisconsin will have to expand medical education greatly if it's going to meet future needs, a governor's task force was told April 17. A committee of the task force on medical education, headed by Donald C. Slichter, prepared a report indicating Wisconsin has 119 doctors for every 100,000 residents, 27th in the nation. It ranked 11th in number of dentists, 61 per 100,000.

Wisconsin was 18th in number of nurses, 4th in general hospital beds, 5th in mental hospital beds, 11th in general hospital admission, and 14th in mental hospital admissions.

Wisconsin's present capacity "will barely maintain the existing (doctor) ratio, which would be far below the projected 1975 national average," the report said. The committee predicted the national ratio in 1975 will be 165 per 100,000.

The report estimated 190 new physicians are graduated each year from Marquette University and the University of Wisconsin, and some of these doctors leave the state after graduation.

During a discussion of the report at a press conference, Dr. Robert D. Coye, assistant dean of the University of Wisconsin Medical School, stated that "planning for the future expansion of Wisconsin's medical educational capabilities should be directed to the goal of 325 first year places in 1971 to produce 120 MDs per 100,000 population by 1975 and to provide adequate medical educational opportunities within the state." He indicated that he did not mean that he was advocating a new medical school—rather, he wanted 125 more first year places for medical students.

Doctor Coye is chairman of a UW committee studying the feasibility of a medical school at UW–Milwaukee. The committee's work is not yet finished and no recommendation has been made regarding a new school, Doctor Coye said after the meeting.

Medical Staff Officers, St. Francis Hospital

New medical staff officers of St. Francis Hospital in La Crosse are: president, *Dr. J. R. Richter;* president-elect, *Dr. A. W. Hickey;* and secretary–treasurer, *Dr. J. T. Murphy*, all of La Crosse.

Dr. Kory Named to Heart Group

Dr. Ross Kory of Wood was named president-elect of the Wisconsin Heart Association at its annual meeting in Wauwatosa April 29.

Dr. Collentine Speaks to Dietitians

Dr. George E. Collentine, Jr. of Milwaukee was guest speaker at the spring conference of the Wisconsin Dietetic Association, held in April at Milwaukee. His subject was "Diet in the Care of Treatment of Burn Patients."

Doctor Schilling Symposium Panelist

Dr. Robert F. Schilling of Madison was one of five panelists at a symposium of the medical department of the Thomas M. Fitzgerald Mercy Hospital, Darby, Pa., June 1. The nationally prominent hematologists discussed "The Anemias." Doctor Schilling is a professor of medicine at the University of Wisconsin Medical School.

Dr. R. F. Schilling

Dr. Peter L. Eichman, dean of the University of Wisconsin Medical School, was guest speaker at the dinner. He served his internship at the hospital. About 400 physicians, medical students, interns, and residents of the Delaware Valley area attended.

Dr. Siegel Receives Humanitarian Award

Dr. Morris Siegel of Kenosha received the Eleanor Roosevelt Humanities Award at an Israel Bond dinner June 4 in Beth Hillel Temple, Kenosha. He was chosen to receive the award for his "many years of exceptional service in promoting the spirit of brotherhood and humanitarianism, and for his devoted efforts in numerous worthwhile causes which benefit mankind." The presentation was made by the State of Israel Bonds in Wisconsin, an organization which provides the means for the upbuilding of a nation, through scientific achievement.

Dr. Morris Siegel

Dr. Behnke at Food Services Clinic

Dr. George Behnke, Kaukauna city health officer and speaker of the State Medical Society's House of Delegates, participated in a two-day restaurant and food service personnel clinic held in May at Kaukauna.

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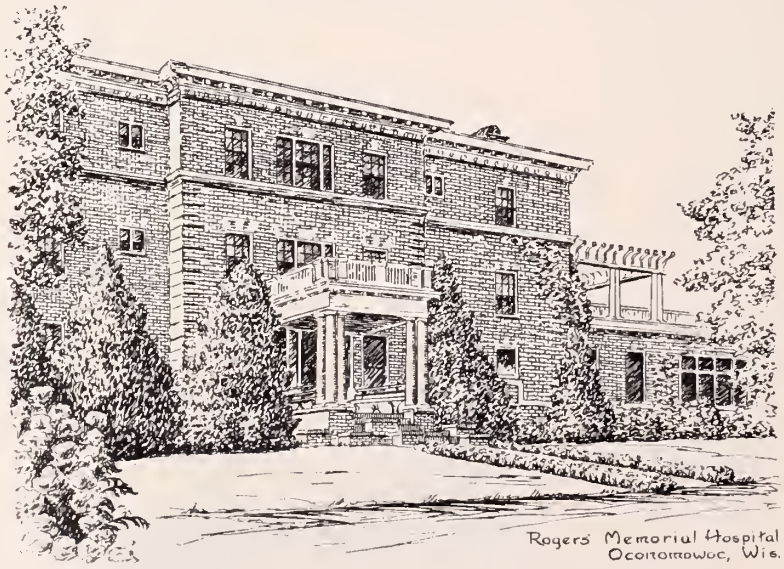

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COUNTY SOCIETY PROCEEDINGS

ASHLAND–BAYFIELD–IRON

Members of the Ashland–Bayfield–Iron County Medical Society met with their wives at a dinner meeting at the Platter in Ashland April 13. Presiding at the meeting was *Dr. J. M. Jauquet*, president-elect. During the dinner, *Dr.* and Mrs. *L. W. Moody* of Bayfield, were presented a floral gift by the Society as a farewell token. The Moodys were to leave soon for their home in northern Minnesota.

Addressing the Society were Glenn Waldschmidt, regional representative for the State Medical Society, who discussed the Medicare program as handled by the Society's insurance division, Wisconsin Physicians Service; and Mrs. Jernstedt, coordinator of the Medicare program for the Ashland, Bayfield, and Iron counties, who spoke on "Home Health Agency."

The wives adjourned to a separate meeting for organizing into an Auxiliary unit.

BARRON–WASHBURN–SAWYER–BURNETT

The April meeting of the Barron–Washburn–Sawyer–Burnett County Medical Society was in the form of a postgraduate seminar with specialists in obstetrics, gynecology, and anesthesiology, from Eau Claire and Minneapolis, speaking. Speakers were Dr. Richard Engwall of Swedish Hospital, Minneapolis, and *Dr. Eldon Hill* of Eau Claire. It was held at Dianne's Supper Club in Chetek with approximately 40 physicians and their wives in attendance.

CHIPPEWA

Dr. Gail Williams of the Marshfield Clinic was the featured speaker at the May 2 meeting of the Chippewa County Medical Society at Reiter's Steak House in Chippewa Falls. His subject was "Breast Tumors."

DANE

There was no May meeting of the Dane County Medical Society due to the State Medical Society annual meeting in Milwaukee.

New members are: *Dr. Gertrude E. Howe*, director of the Section on Community Health Services and director of the Division of Maternal and Child Health of the State Board of Health; *Dr. Richard E. Rieselbach*, assistant professor of medicine at the University of Wisconsin Medical School; *Dr. Maxie C. Maultsby, Jr.*, resident in psychiatry at University Hospitals; and *Dr. Francis W. Parnell, Jr.*, resident in otolaryngology at University Hospitals, all of Madison.

DODGE

After more than 40 years of active practice and esteemed recognition, *Dr. Robert R. Roberts* of Beaver Dam has ended his professional work. The Dodge County Medical Society honored him with a testimonial dinner May 27 at the Old Hickory Golf Club, Beaver Dam.

Nearly 45 years ago Doctor Roberts graduated from Rush Medical college. He had previously completed graduate education at the University of Wisconsin. With a surgical residency completed at Rochester General Hospital of New York, he established practice in Beaver Dam in 1923. "To this challenge, with a steady appetite for work and the broadest kind of vision, this man dedicated himself," it was pointed out at the dinner.

Since that time an outstanding record of professional service and sacrifice has marked the years. His leadership in the medical community was honored when he accepted appointment as the first chief-of-staff of Lutheran Deaconess Hospital in 1947. He served in this capacity again in 1951 and in 1952.

DOUGLAS

The Douglas County Medical Society recently indicated its support of a health policy suggesting physical examinations every three years for Superior public school children, according to *Dr. Enzo Krahl*, president. The Society's position was sought by Kenneth Ripple, superintendent of schools, who had made a proposal to the Board of Education for its inclusion in administrative policies. Recommended are checkups prior to the child's entering school, before the fourth grade, and during the seventh and tenth grade years.

LA CROSSE

Earl Thayer, secretary of PACE—Professional Association for Civic Education—addressed members of the La Crosse County Medical Society at its meeting April 17.

MONROE

Physicians in the Sparta area and the Sparta Kiwanis Club recently cosponsored a pilot series of diabetic meetings, with an attendance of 21. The group consisted of people with diabetes and key family members who share in the diabetic's responsibilities of managing his disorder.

OCONTO

The Oconto County Medical Society held its April meeting at the Lilac Club. *Dr. George Magnin* and *Dr. Ben Lawton* of the Marshfield Clinic spoke to the group on the treatment of stroke victims.

Physicians whose names appear in italics are members of the State Medical Society.

WAUKESHA

The March 11 meeting of the Waukesha County Medical Society was held at the Lakelawn Resort in Delavan as part of a clinic day in conjunction with the Tri-County Academy of General Practice. On April 5 the County Society met at Aliota's on Bluemound in Waukesha.

Dr. Lyle D. Franzen, director of Waukesha County Board of Health, was accepted as a new member; and *Dr. Clarence W. Jordahl, Jr.*, director of Waukesha County Institutions, was accepted as a transfer from Milwaukee County.

NINTH COUNCILOR DISTRICT

The annual spring meeting of the Ninth Councilor Medical District was held April 26 at the Hotel Whiting in Stevens Point. The district includes Lincoln, Marathon, Clark, Wood, Portage, Waupaca, Waushara, and Green Lake counties.

Guest speaker was *Dr. William S. Middleton* of Madison, who is dean emeritus of the University of Wisconsin Medical School and currently a consultant for the Veterans Administration Hospital in Madison. He spoke on the ascendancy and problems of new drugs. Doctor Middleton was accompanied to Stevens Point by his wife and Mrs. Harold Coon. Mrs. Coon's late husband and his father were formerly owners and medical directors of the River Pines Sanatorium at Stevens Point.

In an election of officers, *Dr. Francis E. Gehin* of Stevens Point was elected president to succeed *Dr. David J. Sievers* of Berlin. *Dr. Russell C. Darby* of Wautoma was elected vice-president to succeed *Dr. John Steiner* of Waupaca. Secretary-treasurer is *Dr. Russell Lewis* of Marshfield to succeed Doctor Gehin.

WAUKESHA TETANUS PROGRAM

Tetanus shots recently were offered all personnel of the Waukesha water utility as part of an employes' safety program. Other industries in the city are encouraging similar programs. Arrangements were made through the county health department and a local physician for administering the tetanus shots to employes at one time.

MORE IMMUNIZATION CLINICS . . .

Seven more counties have organized measles immunization clinics. They are: Pepin, Adams, Brown, Manitowoc, Green Lake, Waushara, and Clark.

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SPECIALTY SOCIETY PROCEEDINGS

Wisconsin Society of Public Health Physicians

Dr. Thorn L. Vogel of Janesville has been elected new president of the Wisconsin Society of Public Health Physicians. Secretary-treasurer is *Dr. Josef Preizler* of Madison. *Dr. Ruth E. Church* of Waukesha has been elected Section Delegate to the State Medical Society and Dr. Frank Reider of Madison, alternate delegate.

SMS Section on Anesthesiology

At the recent meeting of the Section on Anesthesiology of the State Medical Society, May 11, it was the motion of the section that the officers, president and secretary, shall be the same as that of the Wisconsin Society of Anesthesiologists. Their term will continue through the year 1967 until October 1968. The president is *Dr. Fred D. Cook* of Green Bay and the secretary, *Dr. Ruth A. Stoerker* of Madison.

The new delegates elected to represent the section at State Medical Society meetings are: *Dr. Sheldon Burchman* of Milwaukee, delegate; and *Dr. John William Temple* of Wauwatosa, alternate delegate. These delegates succeed *Drs. Harry Thimke* of Eau Claire and *David Noll* of Verona.

Milwaukee Gynecological Society

Dr. William P. Wendt, Elm Grove, has been elected president of the Milwaukee Gynecological Society for 1967–1968. Named president-elect was *Dr. John R. Evrard*, Milwaukee. *Dr. William J. Madden*, Racine, was reelected secretary-treasurer.

Milwaukee Neuro-Psychiatric Society

At the May 17 meeting of the Milwaukee Neuro-Psychiatric Society, the following officers were elected for the coming year: president, *Dr. Ervin Teplin;* president-elect, *Dr. Preston W. Thomas;* secretary, *Dr. William H. Studley;* treasurer, *Dr. Leo B. Perssion*, all of Milwaukee; councilors, *Drs. James A. Alston* of Waukesha and *Jean P. Davis* and *Jules D. Levin* of Milwaukee.

Physicians whose names appear in italics are members of the State Medical Society.

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Physicians Assist at Annual Clinic

The annual congenital and rheumatic heart disease clinic for Wood and Portage counties was held recently at Wisconsin Rapids. The clinic was conducted by the Wisconsin Heart Association as a consultation service. *Dr. Richard H. Wasserburger*, cardiologist, and *Dr. William H. Ylitalo*, pediatrician, both of Madison, were the examining physicians.

School Health Education Workshop

The University of Wisconsin in cooperation with The Johnson Foundation of Racine sponsored a School Health Education Workshop at Wingspread May 4–6.

Purpose of the meeting was outlined by the sponsors as follows:

Strongly motivated and well-informed teachers are in a good position to assist in the development of community resources for healthful living, health services, and health instruction. Moreover, teachers have continuing opportunities to observe the behavior of individual children; if they can learn to recognize syndromes indicating organic and emotional disorders, they may be able to initiate programs leading to effective therapy. These programs would often involve the parents of the children being helped. This Institute on School Health Education is intended to provide teachers with a basic background of information on these subjects which will enable them to take leadership roles in their own communities.

Participants in the program included: O. R. Cade, Director, Community Health Education Service, State Board of Health; Warren H. Southworth, Dr.P.H., and Professor of Health Education, Department of Curriculum and Instruction, UW; Luida Sanders, Supervisor of Health Education, State Department of Public Instruction; Raymond Nashold, Director, Statistical Service Division, State Board of Health; *Dr. Robert J. Samp*, University of Wisconsin Medical School and Education; Rex T. Duter, Superintendent, Wisconsin School for Girls, Oregon; *Dr. Jack Edson*, Consulting Psychiatrist, School for Boys, Wales; *Dr. Jack Westman*, Professor, Department of Psychiatry, UW; *Dr. H. Kent Tenney*, Emeritus, Clinical Professor of Pediatrics, UW; Thomas Berk, Consultant, Metropolitan Life Insurance Company, New York City;

Esther Kovenock, Consultant, Division of Child Behavior and Development, State Board of Health; Timothy Ryan, D.D.S., State Dental Society; *Dr. Abraham Schwartz*, Department of Pediatrics, Children's Hospital, Milwaukee; Dr. Elliot Dick, Associate Professor of Preventive Medicine, UW Medical School; Wallace Ann Wesley, Hs.D., Assistant Director, Department of Health Education, American Medical Association, Chicago; Elizabeth Ryan, United States Public Health Service, Cancer Control Division; Elizabeth Sullivan, Milwaukee Dairy Council; Dr. Vernon J. Forney, Medical Director of Region V, Public Health Services; William H. Cresswell, Jr., Ed.D., and Professor, Department of Education, University of Illinois, Urbana; and Thomas Janeway, Superintendent of Health Education, State of Illinois, Springfield.

Physicians whose names appear in italics are members of the State Medical Society.

PARAMEDICAL ANCILLARY GROUPS

Free Forum on Heart Disease

The Milwaukee county unit of the Wisconsin Heart Association conducted a free forum on care and prevention of heart disease May 21 at the vocational school. Speakers were three Milwaukee heart specialists, Drs. *Thomas C. Puchner*, *Mischa Lustok*, and Richard E. Friesendorf.

Hospital Group Honors Vincent Otis

Vincent F. Otis, director of the Division of Hospital and Related Services of the State Board of Health, was presented the Award of Merit of the Tri-State Hospital Assembly at its annual meeting in Chicago May 1–3. The award, given "in recognition of outstanding leadership and unselfish service," was presented to Mr. Otis by Glen L. Maher, president of the Wisconsin Hospital Association. This is believed to be the first time the award has been presented to an official of a state agency concerned with hospital regulation.

Mr. Otis has had a long and productive relationship with hospitals in Wisconsin. When it became evident that Congress would extend federal aid to the construction of hospitals, the Wisconsin Legislature in 1945 adopted a hospital survey act, to be administered by the State Board of Health, and Mr. Otis was chosen to direct it. In 1947, when federal aid for hospitals became a reality the name was changed to the Division of Hospital Survey and Construction. The state plan for the construction and modernization of hospitals required by the federal act brought closer cooperation between the hospitals and the state agency. Mr. Otis continued as director when the name was again changed in 1952 to the Division of Hospital and Related Services.

Mr. Otis was born in Milwaukee and attended the schools in that city. He earned certificates in accounting and in business administration from the University of Wisconsin Extension Division. Prior to his affiliation with the State Board of Health he was business administrator at Milwaukee County Institutions. He has written numerous articles on hospitals and health related institutions and has received several awards and citations, including the Wisconsin Hospital Association's Award of Merit in 1959.

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PARAMEDICAL/ANCILLARY *continued*

Robert M. Jones, administrator of Waukesha Memorial Hospital, Waukesha, was elected treasurer of the Assembly. Mr. Jones has been administrator of the Waukesha hospital since 1954. He also served at Columbia Hospital in Milwaukee and in the U.S. Army. He is a former president of the Wisconsin Hospital Association.

About 12,000 registrants attended the meeting which covers hospitals in Wisconsin, Illinois, Indiana, and Michigan.

New Emergency Service Plan at St. Michael's

Police, fire, and other public officials from the City of Milwaukee and northeastern suburbs attended a briefing session at St. Michael Hospital April 29 to hear physicians from the medical staff and members of the hospital administration explain the new emergency service which went into effect at the hospital May 1.

The plan, designed to provide faster and better emergency service is the result of a study undertaken by the St. Michael Medical Staff Emergency and Disaster Committee headed by *Dr. Richard J. Krill.*

Sister M. Illumina, administrator of St. Michael Hospital, stated that as far as it is known this is the first such emergency plan in operation in the State of Wisconsin. It is currently in operation in several other metropolitan areas in the United States.

Marquette Lecturer Discusses LSD

A medical authority on the hallucinatory drug LSD told the "LSD Story" to scientists and educators May 10 at the Marquette medical school auditorium, Milwaukee.

Dr. Sidney Cohen, who is chief of psychiatry at Wadsworth V. A. Hospital in Los Angeles and associate professor of pharmacology at the University of California, in Los Angeles, spoke at the first annual Marquette Medical School Student American Medical Association lecture. Other sponsors were Roche Laboratories and the Marquette medical school pharmacology department.

Doctor Cohen has made extensive studies on the drug in connection with its use on psychiatric patients. He is the author of numerous articles and two books on LSD, "The Beyond Within: the LSD Story" and "LSD."

"Defensive Driving Classes"

St. Michael Hospital, in cooperation with the Milwaukee Safety Commission, in April and May instituted a series of "defensive driving classes" aimed at helping to prevent the ever-increasing number of traffic accidents and automobile injury victims.

The program is in keeping with a policy being undertaken by the hospital to participate in community education activities whenever possible in the field of health education and accident prevention.

Approved by the National Safety Council, personnel from the Milwaukee Safety Commission conducted the classes.

British Surgeon Lectures at Marquette

An eminent British surgeon, who lectured in Milwaukee in late April as the visiting professor of cardiovascular surgery at Marquette University School of Medicine, said that "a mechanistic approach to life" in the United States sometimes was inappropriate for solving medical problems. The visitor was Lord Russell Brock of London, who was elevated to the peerage two years ago for his contributions to knowledge in treatment of abnormalities of the esophagus and improvements in heart surgery.

Doctor Brock participated in surgery and lectured at the Veterans Administration, Milwaukee Children's, and County General hospitals. His visit to Milwaukee was sponsored by the medical school, the Wisconsin Anti-Tuberculosis Association, the Milwaukee division of the American Cancer Society, and the VA.

Sheboygan Lung Cancer Panel

Approximately 100 Sheboygan county teenagers took part in the "meet the press-type" of news conference on smoking and lung cancer April 27. The session was sponsored by the American Cancer Society and the staff of the South High Lake Breeze. A panel of doctors moderated by *Dr. Bernard Marsho* answered questions from high editors, news collectors, and writers who were to take the results of the discussion back to their own school communities. Discussants with Doctor Marsho were *Drs. P. A. Sciarra, Howard Mueller, Raymond Evers,* and *Herman Dick.*

Joint Clinic Day for Milwaukee Hospital

The 1967 joint conference clinic day, started three years ago by Trinity Memorial Hospital, was held April 29 at the Red Carpet Inn in Milwaukee. The subject was kidney disease.

Speakers included Drs. David Hume, professor and chairman of surgery at the University of Virginia medical school; W. Newlon Tauxe, chief of the Mayo Clinic isotope laboratory; Joseph H. Holmes, professor of medicine at the University of Colorado, Denver; and Conrad L. Pirani, chairman of the University of Illinois pathology department.

This year's conference was sponsored by Trinity Memorial and St. Francis, St. Luke's and West Allis Memorial hospitals.

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PARAMEDICAL/ANCILLARY GROUPS

continued

Election of Physical Therapist Group

New officers of the Wisconsin Chapter of the American Physical Therapy Association following election on April 29 are: president, Art Grisa of Brookfield; vice-president, Douglas Inman of Madison; secretary, Marta Mueller of Madison; treasurer, Mary Ann Morrison of Milwaukee; directors, Janet Lemke and Dan Strelnick of Milwaukee.

Workshop on Cardiovascular Disease

More than 100 health agency executives and business leaders participated in the Wisconsin follow-up workshop to the Second National Conference on Cardiovascular Disease at the Wisconsin Center, Madison, May 31. It was sponsored by the Wisconsin Heart Association, Wisconsin State Board of Health, and the State Medical Society of Wisconsin.

Health and industrial leaders throughout Wisconsin who deal with the state's 25,000 cardiac victims, together with physicians, nurses, and business executives discussed the limitations and potential in Wisconsin of carrying out the practices recommended by the National Conference.

Dr. John Rankin, Madison, professor of medicine at the University of Wisconsin Medical Center and chairman of the workshop, expressed hope that through this workshop "communications between health agencies will be improved and the resulting actions of benefit to Wisconsin cardiacs in the near and distant future."

Wisconsin Public Health Association Elections

Michael C. Arra, D.D.S., was installed as president of the Wisconsin Public Health Association at the annual meeting at the Wisconsin Center, Madison, May 24. Doctor Arra is director of the dental health division of the State Board of Health. He succeeds L. A. Penn, who is director of the technical services division of the Milwaukee Health Department.

In the election of officers Miss Vivian Holland, health educator with the Madison Health Department, was chosen president-elect and will take office at the 1968 annual meeting. Vice-president is Mrs. Martha Kjenvet, nutrition consultant in the Eau Claire district of the State Board of Health. Charles Lemke, director of research of the State Board of Health, is the secretary–treasurer.

Dedication Held for Retarded Center

The first complete mental retardation center to be built in the nation, according to its director, Robert Allen, was dedicated June 4 at Green Bay. Approximately 400 retarded clients can be served at one time by the $913,000 facility. Counties whose residents are eligible to purchase the services on a fee basis if they wish are Door, Kewaunee, Calumet, Outagamie, Waupaca, Shawano, Menominee, Oconto, and Marinette.

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Precautions: Obtain a detailed history and a complete physical and laboratory examination, including a blood count. The patient should be closely supervised and should be warned to report immediately fever, sore throat, or mouth lesions (symptoms of blood dyscrasia); sudden weight gain (water retention); skin reactions; black or tarry stools or other evidence of intestinal hemorrhage. Make regular blood counts. Discontinue the drug and institute countermeasures if the white count changes significantly, granulocytes decrease, or immature forms appear. Use greater care in the elderly and in hypertensives.

Adverse Reactions: The most common are nausea, edema and drug rash. The drug has been associated with peptic ulcer and may reactivate a latent peptic ulcer. Infrequently, agranulocytosis, or a generalized allergic reaction may occur and require withdrawal of medication. Stomatitis, salivary gland enlargement, vomiting, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported but cannot definitely be attributed to the drug. Thrombocytopenic purpura and aplastic anemia may occur. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hyperglycemia, hepatitis, jaundice, and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently. Moderate lowering of the red cell count due to hemodilution may occur.

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Brooks, Kenneth H., 4116-23rd Ave., Kenosha 53140
Cafaro, John R., 5000 West Chambers St., Milwaukee 53210
Felion, Paul L., 1836 South Ave., La Crosse 54601
Fischer, Herbert K., 630 South Central Ave., Marshfield, 54449
Friend, Charles R., 630 South Central Ave., Marshfield 54449
Gordon, Robert P., Jr., 630 South Central Ave., Marshfield 54449
Hacker, Philip K., 2501 Main St., Stevens Point 54481
Haight, Robert Peterson, Jr., 630 South Central Ave., Marshfield 54449
Hardacre, Jerry M., 630 South Central Ave., Marshfield 54449
Hinke, Marvin L., 630 South Central Ave., Marshfield 54449
Howe, Gertrude E., P. O. Box 309, Madison 53701
Hussussian, Jacques, 10425 West North Ave., Wauwatosa 53226
Johnson, Sidney E., 630 South Central Ave., Marshfield 54449
Lyons, Charles R., 1633 Elmwood, Apt. 3, Oshkosh, 54901
Malewiski, Larry J., 1930 North Eighth St., Sheboygan 53081
Maultsby, Maxie C., Jr., 702 Huron Hill, Madison 53711
Mejia, Gualberto B., 240 Allen St., Clinton 53525
Montenegro, Jose V., III, 3866 North 55th St., Milwaukee 53216
Norfleet, Robert G., 630 South Central Ave., Marshfield 54449
Pandazi, Andrew A., 3203 North 50th St., Milwaukee 53216
Parnell, Francis W., Jr., 2242 Allied Dr., Madison 53711
Reyes, Cesar N., Jr., St. Joseph's Hospital, Marshfield 54449
Rieselbach, Richard E., 1300 University Ave., Madison 53706
Sattler, James R., 630 South Central Ave., Marshfield 54449
Sladky, James A., 2900 West Oklahoma Ave., Milwaukee 53215
Schroeder, Daniel J., Jr., 127 Keller Ave. North, Amery 54001
Tankersley, James C., 1707 Main St., La Crosse 54601
Vangor, Donald William, Box 325, Wisconsin Dells, 53965
Voss, Dieter M., 630 South Central Ave., Marshfield 54449
Zurek, W. Z., 630 South Central Ave., Marshfield 54449

REINSTATED

Dryer, Raymond Brown, Poynette 53955

CHANGES OF ADDRESS

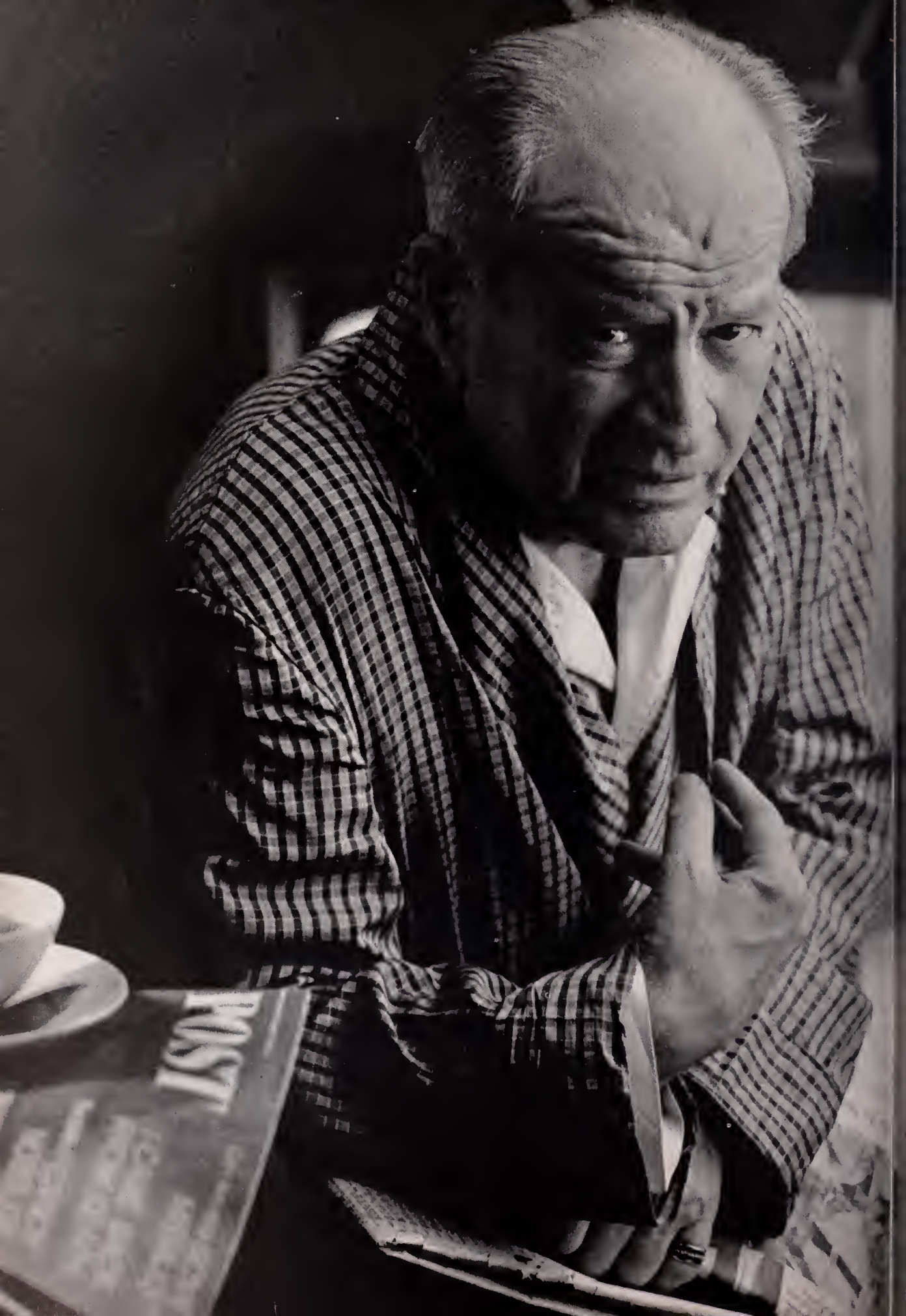
Barbour, James H., Madison, to Box 305, Green Lake 54941
Barreto, R.S.A., Madison, to 4525 West Dean Road, Milwaukee 53223
Bellehumeur, Gerald C., 8157 North Green Bay Rd., Milwaukee 53209

SOCIETY RECORDS

Bookhamer, James W., 2450 Swan Blvd., Milwaukee 53213
Damiano, Nicholas F., 5757 South 108th St., Hales Corners 53130
Davis, John B., Madison, to Route 1, Sunset Drive, Verona 53593
Eckert, Gordon L., 6236 South Highlands, Madison 53705
Flint, Charles H., Minocqua, to 10604 W. Michigan Ave., Wauwatosa 53226
Guhl, James F., 5757 W. Oklahoma Ave., Milwaukee 53219
Hanson, Emmet R., Elm Grove, to 5757 W. Oklahoma Ave., Milwaukee 53219
Heinz, Harold, 1930 North Eighth St., Sheboygan 53081
Henschel, Ann Bardeen, Wood, to 8700 W. Wisconsin Ave., Milwaukee 53226
Hensley, George T., Milwaukee, to 2363 N. 103rd St., Wauwatosa 53226
Jerofke, Alfred M., Milwaukee, to 3567 E. Barnard Ave., Cudahy 53110
Marlow, Gordon V., 20 South Park St., Madison 53715
Mastalir, Lester O., 3272 North 92nd St., Milwaukee 53222
Mills, E. Grady, Oconomowoc, to 250 Buffalo St., Mondovi 54755
Milson, Stuart E., Fort Carson, Colo., to USARV Tran DET, APO San Francisco 96307, Calif.
Owen, John D., Sierra Vista Ranch Box 326, Cave Creek, Ariz., 85331
Rufflo, Robert A., 5757 West Oklahoma Ave., Milwaukee 53219
Savage, George F., 125 North Franklin, Port Washington 53074
Shapiro, David, Wisconsin Rapids, to 208 E. Wisconsin Ave., Milwaukee 53202
Sorenson, Robert I., 5757 West Oklahoma Ave., Milwaukee 53219
Stein, Leonard I., Madison, to 3469 Flintridge Drive, Lexington, Kentucky 40502
Stewart, Katherine E., 532 Summit Ave., Eau Claire 54701
Stiehl, C. W., Algoma, to 2740 West Forest Home, Milwaukee 53215
Thranow, John A., Milwaukee, to Box 541, La Belle, Florida 33935
Treacy, William L., 10125 West North Ave., Milwaukee 53226
Wallestad, P. W., 309 East Norport Drive, Port Washington 53074
Wolfgram, Richard C., 2121 Bowen Street, Oshkosh 54901

REMOVED FROM MEMBERSHIP

Bittle, Kenneth A., Winnebago County, transferred to California.
Borenz, Harold Frank, Dane County.
Cohill, Donald F., Shawano County, resigned.
Denzel, Herman A., Winnebago County, resigned.
Ehrhardt, Alan A., Winnebago County, transferred to Maryland.
Goedecke, Raymond H., La Crosse County, resigned.
Szymanski, Jerome F., Winnebago County, transferred to Arizona.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Contraindications: History of sensitivity to meprobamate.

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SOCIETY RECORDS *continued*

Von Ruden, William John, Shawano County, resigned.
Whiteway, Robert E., La Crosse County, resigned.
Winter, Bruce V., Racine County.

DEATHS

Schumacher, Hyman S., Milwaukee County, Mar. 17, 1967
Bock, A. B. C., Sheboygan, Mar. 23, 1967
Tasche, Conrad T., Sheboygan County, Mar. 31, 1967

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Pressure sores and other kinds of skin breakdown generally can be prevented with good skin care. The all too common neglect of effective preventive measures indicates need for a comprehensive guide to skin care.

"Nursing Care of the Skin," newly published by the American Rehabilitation Foundation, makes available a detailed presentation of the subject.

Designed primarily as a management guide for nurses, the 26-page manual describes measures for preventing pressure sores and other skin complications which cause so much discomfort and necessitate prolonged treatment.

The handbook also reviews methods of protecting the skin against common injuries. Instruction of both patients and families in skin care techniques for home use is stressed.

Written by members of the Nursing Education Department, the manual is one in a series prepared by the American Rehabilitation Foundation/Kenny Rehabilitation Institute staff. Development of the publications has been supported, in part, by the Vocational Rehabilitation Administration and the Division of Chronic Diseases, U. S. Public Health Service.

Copies may be obtained for 85 cents each from the Publications Division, American Rehabilitation Foundation, 1800 Chicago Avenue, Minneapolis, Minnesota 55404.

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Contraindications: History of previous hypersensitivity to oxazepam. Oxazepam is not indicated in psychoses.

Precautions: Hypotensive reactions are rare, but use with caution where complications could ensue from a fall in blood pressure, especially in the elderly. Withdrawal symptoms upon discontinuation have been noted in some patients exhibiting drug dependence through chronic overdose. Carefully supervise dose and amounts prescribed, especially for patients prone to overdose; excessive, prolonged use in susceptible patients (alcoholics, ex-addicts, etc.) may result in dependence or habituation. Reduce dosage gradually after prolonged excessive dosage to avoid possible epileptiform seizures. Withdrawal symptoms following abrupt discontinuance are similar to those seen with barbiturates. Caution patients against driving or operating machinery until absence of drowsiness or dizziness is ascertained. Warn patients of possible reduction in alcohol tolerance. Safety for use in pregnancy has not been established.

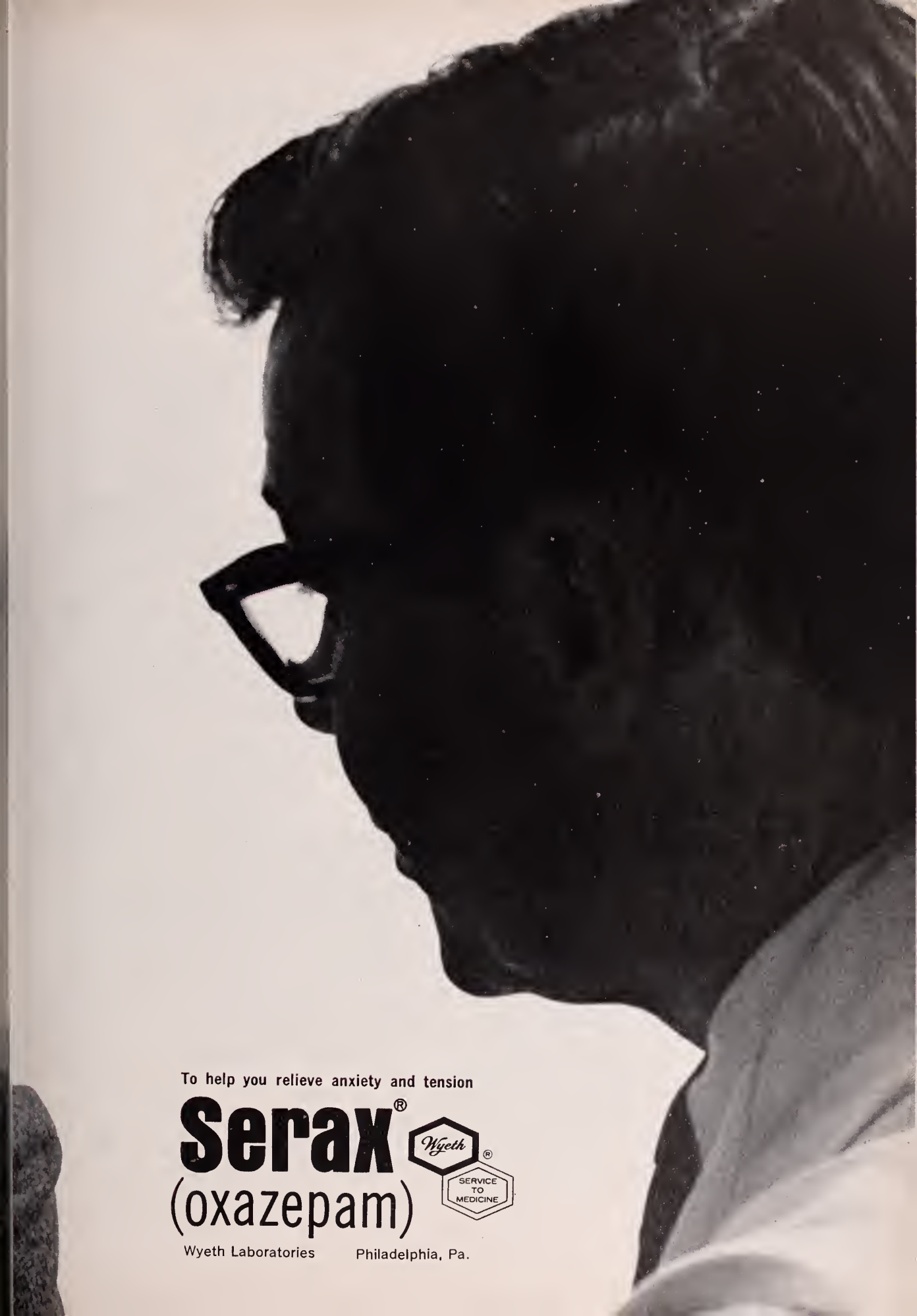
Not indicated in children under 6 years; absolute dosage for 6- to 12-year-olds, not established.

Side Effects: Therapy-interrupting side effects are rare. Transient mild drowsiness is common initially; if persistent, reduce dosage. Dizziness, vertigo and headache have also occurred infrequently; syncope, rarely. Mild paradoxical reactions (excitement, stimulation of affect) are reported in psychiatric patients. Minor diffuse rashes (morbilliform, urticarial and maculopapular) are rare. Nausea, lethargy, edema, slurred speech, tremor and altered libido are rare and generally controllable by dosage reduction. Although rare, leucopenia and hepatic dysfunction including jaundice have been reported during therapy. Periodic blood counts and liver function tests are advised. Ataxia, reported rarely, does not appear related to dose or age.

These side reactions, noted with related compounds, are not yet reported: paradoxical excitation with severe rage reactions, hallucinations, menstrual irregularities, change in EEG pattern, blood dyscrasias (including agranulocytosis), blurred vision, diplopia, incontinence, stupor, disorientation, fever and euphoria.

Availability: Capsules of 10, 15 and 30 mg. oxazepam.

Photograph posed by professional models.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MEDICAL MEETINGS

POSTGRADUATE COURSES

1967 WISCONSIN

Aug. 24–26: Conference on "Current Concepts in Surgery" sponsored by the Department of Surgery, UW Medical Center, at Wisconsin Center, Madison.

Sept. 14: Adolf Gundersen Medical Foundation and Wisconsin Heart Association Symposium on Stroke, at Wisconsin State University at La Crosse.

Sept. 15–16: Annual meeting, Wisconsin Society of Internal Medicine, The Gateway Hotel and Inn, Land O' Lakes.

Sept. 16–17: Annual fall meeting, Wisconsin Society of Anesthesiologists, The Pioneer, Oshkosh.

Sept. 27–29: Annual meeting and scientific assembly, Wisconsin Academy of General Practice, Pfister Hotel, Milwaukee.

Oct. 9–20: Advanced Maternity Program in Delivery Room Nursing for graduate nurses, Marquette University College of Nursing, Milwaukee

Oct. 16–20: Wisconsin Work Week of Health, State Medical Society of Wisconsin, Madison.

Oct. 16–21: Postgraduate course, "Basic and Clinical Aspects of Therapy in Advanced Cancer," University of Wisconsin Medical Center, Madison.

Oct. 21: Annual fall cancer conference (The Cancer Scrimmage), University of Wisconsin Medical Center, Madison.

Nov. 6–17: Advanced Maternity Program in Delivery Room Nursing for graduate nurses, Marquette University College of Nursing, Milwaukee.

Nov. 13–14: Quackery conference, sponsored by State Medical Society of Wisconsin, Milwaukee Auditorium.

Nov. 17: Medical-Legal-Industrial Symposium on "Pulmonary Diseases in Industry," sponsored by Mount Sinai Hospital, at Pfister Hotel, Milwaukee.

1968 WISCONSIN

Jan. 15–26: Advanced Maternity Program in Delivery Room Nursing for graduate nurses, Marquette University College of Nursing, Milwaukee.

Feb. 12–23: Advanced Maternity Program in Delivery Room Nursing for graduate nurses, Marquette University College of Nursing, Milwaukee.

Mar. 11–22: Advanced Maternity Program in Delivery Room Nursing for graduate nurses, Marquette University College of Nursing, Milwaukee.

Apr. 22–May 3: Advanced Maternity Program in Delivery Room Nursing for graduate nurses, Marquette University College of Nursing, Milwaukee.

1967 NEIGHBORING STATES

Aug. 14–18: Golden anniversary, American Dietetic Association, Conrad Hilton Hotel, Chicago, Ill.

Sept. 21–23: Annual meeting, American Association of Medical Clinics, Drake Hotel, Chicago, Ill.

Aug. 21–24: 69th Annual Meeting, American Hospital Association, International Amphitheater, Chicago.

Sept. 21–24: Annual meeting of American Medical Writers' Association, Palmer House, Chicago, Ill.

Oct. 2–6: Annual clinical congress, American College of Surgeons, Chicago.

Oct. 4–5: Annual Midwest Interprofessional Seminar on Diseases Common to Animals and Man, University of Missouri, Columbia.

Oct. 11: Third Annual Kidney Disease Symposium, Sheraton-Chicago Hotel, Chicago.

Oct. 12–13: Head and Neck Radiology Conference, Department of Radiology, College of Medicine of the University of Illinois, Chicago.

Oct. 14–20: Annual Otolaryngologic Assembly, at Illinois Eye and Ear Infirmary, Medical Center, Chicago.

1967 OTHERS

Sept. 29–Oct. 3: Annual meeting, American Society of Anesthesiologists, Las Vegas, Nev.

Oct. 21–26: Annual Meeting, American Academy of Pediatrics, Washington, D. C.

Nov. 16–19: Annual convention, National Society for Crippled Children and Adults, Century Plaza Hotel, Los Angeles, Calif.

Nov. 26: Ninth national conference on the medical aspects of sports, in conjunction with the annual clinical convention of the American Medical Association, Nov. 26–29, Houston, Tex.

1968 OTHERS

Jan. 14–18: Second annual meeting of the Society of Cryo-Ophthalmology, Miami Beach, Fla.

May 4–9: Annual teaching seminar, International Academy of Proctology, Montreux–Palace Hotel, Montreux, Switzerland.

Oct. 21–25: Annual Clinical Congress, American College of Surgeons, Atlantic City, N.J.

For listing of other meetings see the JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION.

Wisconsin Academy of General Practice

The annual meeting and scientific assembly of the Wisconsin Academy of General Practice has been scheduled for September 27–29 at the Hotel Pfister in Milwaukee.

Delivery Room Nursing Courses at Marquette

Marquette University College of Nursing has announced the dates of its two-week courses on Advanced Maternity Program in Delivery Room Nursing for graduate nurses.

The program is designed for nurses presently employd in hospitals, or as a refresher program for those graduate nurses who anticipate returning to work in a maternity department. The beginning dates are: Oct. 9, Nov. 6, 1967; and Jan. 15, Feb. 12, Mar. 11, and Apr. 22, 1968.

Applications or inquiries should be directed to: Miss Virginia Mecikalski, R.N., Marquette University College of Nursing, 3029 North 49th Street, Milwaukee, Wis. 53210.

Medical Aspects of Sports Conference

The Ninth National Conference on the Medical Aspects of Sports, sponsored by the American Medical Association under the auspices of its Committee on the Medical Aspects of Sports, will be held in Houston, Tex., at the Hotel America on November 26. The Conference is held annually in conjunction with and on the first day of the Clinical Convention of the American Medical Association.

As was true of the previous eight Conferences, the Ninth will cover a wide range of subjects of interest to those serving school and college athletic programs. Included will be forums and discussion sections relating to prevention of knee injuries, sports cardiology, and quackery in sports. Two sessions will be devoted to a series of common clinical conditions of rather variable significance in the

athletic setting (eg, gastroenteritis, concussions, genitourinary tract injuries, and rib injuries). At the Conference Luncheon, Eduardo Hay, MD, Director General of the Centro Deportivo Olimpico Mexicano, will discuss the preparations for the 1968 Olympic Games.

The Conference is open to key nonmedical athletic personnel as well as interested physicians. Those who would like to receive further information concerning the Conference should address the Committee on the Medical Aspects of Sports, American Medical Association, 535 North Dearborn Street, Chicago, Illinois 60610.

Cancer Course at University of Wisconsin

The University of Wisconsin Medical Center will sponsor a week-long course in the therapy of advanced cancer beginning October 16. The course, open to a limited number of interested physicians, will concentrate on the basic elements and the clinical aspects of advanced cancer therapy. The program will include lectures, seminars, discussions, rounds, and case studies.

Sponsored by the U. W. Medical School's Division of Clinical Oncology, the course—offered for the first time—will seek to acquaint physicians with latest developments in anti-cancer drugs, x-ray therapy, and other cancer treatments.

The program will conclude on Saturday, October 21, with the Medical Center's 13th annual fall cancer conference, a one-day session of intensive cancer instruction.

Further information about the program may be obtained from Dr. Robert J. Samp, assistant professor of clinical oncology at the Medical Center, 1300 University Avenue, Madison, Wis. 53706.

American Academy of Pediatrics Meeting

The 36th annual meeting of the American Academy of Pediatrics will be held in Washington, D. C., October 21–26. Approximately 4,500 pediatricians, their families, and guests are expected to attend.

The meeting, scheduled for the Washington Hilton Hotel, will feature symposiums on manpower and graduate training, learning, advances in obstetrics of interest to pediatricians, vaccine progress and problems, and exciting developments in pediatrics.

Additional general session papers will cover subjects including the recognition and management of cardiac failure in infancy, care of burns at home, and the child with chronic renal (kidney) disease.

The Academy meeting is open to physicians who are not pediatricians. Registration fees are $18.00 for Academy members, applicants to the Academy, applicants to the American Board of Pediatrics, nonmembers out of school less than five years, and physicians in the Armed Forces. Registration fee for nonmember physicians out of school more than five years is $50.00.

Interested physicians may write the AAP, 1801 Hinman Avenue, Evanston, Ill. 60204, for a preliminary program and registration forms.

Western Cardiac Conference, Colorado

The 14th Western Cardiac Conference has been set for August 16–18 at the University of Colorado Medical Center, Denver, by the Colorado Heart Association.

The course is titled Problems in Clinical Cardiology. Guest speakers include the following doctors: C. Walton Lillehei, Minneapolis; Albert Kattus, Los Angeles; Noble Fowler, Cincinnati; Arthur Sasahara, Boston; as well as prominent local speakers from the University of Colorado and private practitioners.

Subjects to be covered include Electrical Pacemakers—Coronary Revascularization, Clinical Coronary Revascularization, Clinical Coronary Disease —Hemodynamic Correlations, Physical Diagnosis—Cardiomyopathies, and Pulmonary Embolism.

For further information: Colorado Heart Association, 1375 Delaware Street, Denver, Colo. 80204.

International Academy of Proctology Seminar

All physicians are cordially invited to attend the 20th Annual Teaching Seminar of the International Academy of Proctology and the 4th Annual Convocation of the International Board of Proctology, at the fabulous Montreux–Palace Hotel, Montreux, Switzerland, May 4–9, 1968.

For full information on the exciting excursions, social and scientific events, please write to the Executive Officer, 147–41 Sanford Avenue, Flushing, N. Y. 11355. For travel arrangements you may write to the Earlfield Agency, 29 Fifth Avenue, Pelham, New York, 10803.

Course in Postgraduate Gastroenterology

The American College of Gastroenterology announces that its annual course in Postgraduate Gastroenterology will be given at The Biltmore in Los Angeles, Calif., November 2–4.

The faculty for the course will be drawn from the medical schools in and around Los Angeles. The subject matter to be covered in the course, from a medical as well as surgical viewpoint, will be, essentially, the advances in diagnosis and treatment of gastrointestinal diseases and a comprehensive discussion of diseases of the esophagus, stomach, pancreas, liver and gallbladder, colon and rectum. In addition there will be individual papers and films of interest.

For further information and enrollment write to the American College of Gastroenterology, 33 West 60th Street, New York, N. Y. 10023.

American Medical Writers' Association

The 27th annual meeting of the American Medical Writers' Association (AMWA) will be held at the Palmer House in Chicago, September 21 to 24.

The program is designed for both physicians and journalists with interest in the field of medical writing. Attendance is open to both members and nonmembers of AMWA.

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President Kief Honored at Reception June 11

The new State Medical Society president, Dr. Harold J. Kief of Fond du Lac, was honored at a President's Reception Sunday, June 11, at State Medical Society headquarters in Madison. About 250 colleagues, business associates, state dignitaries and civic leaders, relatives, and friends attended.

IN THE RECEIVING LINE were Dr. and Mrs. W. D. James of Oconomowoc, president-elect; Dr. and Mrs. H. J. Kief of Fond du Lac, president; and Dr. and Mrs. N. A. Hill of Madison, past president. Dr. F. E. Drew of Milwaukee, the immediate past president was unable to attend as well as the chairman of the Council, Dr. and Mrs. J. C. Fox of La Crosse.

Society Hosts Graduating Medical Students, Families

On Monday, June 5, the State Medical Society held a reception and luncheon for 230 graduating University of Wisconsin medical students, their families, and guests. Members of the Woman's Auxiliary acted as hostesses. It was a time of relaxation after the rush of graduation ceremonies, and it gave them an opportunity to visit and tour the Society headquarters. Picture-taking was a popular activity, with the beautifully landscaped lawn areas serving as a background. A "huge" Wisconsin pennant was staked to the front lawn in full view as visitors peered from the Presidents Room at the shoreline of Lake Monona.

A PORTION OF the special guests.

THREE OF THE AUXILIARY hostesses: Mrs. E. I. Boldon, Mrs. D. M. Britton, and Mrs. L. G. Kilpatrick of Madison. Other hostesses were: Mesdames T. W. Tormey, A. E. Schultz, T. V. Geppert, C. G. Reznichek, and Yoshio Hauda of Madison.

Quackery "Costs" to Be Aired November 13–14 in Milwaukee

The high cost of quackery, in lives and money, will be the theme of this year's quackery conference scheduled for November 13–14 in Milwaukee Auditorium. The public program is an activity of the State Medical Society which has conducted three previous sessions, starting in 1963. Cooperating with this year's program are The Medical Society of Milwaukee County and the Milwaukee Journal Company which has offered the support of its newspapers and radio and television stations.

Among the subjects to be covered by national authorities are quackery in nutrition, marriage counseling, mental health, cancer, devices, arthritis, and heart disease.

Early volunteers of displays and speakers are the American Medical Association, Wisconsin Arth-

ritis Foundation, and the Wisconsin and Milwaukee divisions of the American Cancer Society.

An important goal of the meeting will be an audience of opinion leaders, according to Society president, Dr. Harold J. Kief, of Fond du Lac. "We hope to reach those who can benefit from the facts to be presented but, of equal importance, can pass along the information to others," he said. Special efforts will be made to bring notice of the meeting to parents, school faculties, civic groups, dietitians, therapists, and other health-oriented personnel.

HEART CARE PROBLEMS DISCUSSED

The rapid growth of cardiac care units in state hospitals and the resulting problems came under the scrutiny of heart disease specialists June 8 during a daylong conference in the Wisconsin Center at Madison.

About 150 physicians, nurses, health agency officials, and industrial leaders participated in the Wisconsin Follow-up Workshop to the Second National Conference on Cardiovascular Disease.

William B. Youmans, Ph.D., professor of medicine at the University of Wisconsin, said demands are increasing throughout the state for extensive coronary care units.

A panel which discussed nursing services for cardiac patients adopted a recommendation that the State Medical Society establish minimum standards for cardiac care units in state hospitals.

Mrs. Elizabeth Regan, associate professor of nursing at the UW–Milwaukee, said such centers are springing up throughout the state and that although a set of national standards has been drawn up, none has been adopted in Wisconsin.

The nursing service panel also recommended that nursing and medical educators design a special training program to qualify nurses for assignment at cardiac care centers.

The workshop was sponsored by the State Board of Health, the Wisconsin Heart Association, and the State Medical Society of Wisconsin.

CORRECTION

A case of mistaken identity occurred in the May issue of the JOURNAL at page 24. In the picture of four preceptors, Dr. D. R. Griffith was identified as Dr. G. G. Giffin, both of Eau Claire. Our apologies to Doctor Griffith. Our apologies, also, to Doctor Giffen whose name was misspelled, with an "i" instead of an "e."

REPRINTS OF ARTICLE AVAILABLE ON CORONARY CARE UNIT NURSING

An article on "Nursing in a Coronary Care Unit" has been reprinted by the American Heart Association for distribution to nurses, physicians, and hospital administrators.

Copies of the reprint may be obtained without charge from local Heart Associations or the AHA National Office.

MEETINGS AND SPECIAL EVENTS HELD AT THE STATE MEDICAL SOCIETY "HOME" DURING THE MONTH OF JUNE 1967

1 Madison Board of Health (Madison)
2 Madison Society of Obstetrics and Gynecology
5 Open House and Buffet Lunch, University of Wisconsin Graduating Medical Students
5 WPS Presentation on Titles 18 and 19 to Area Medical Assistants
5 Insurance Advisory Committee, Dane County Medical Society (Madison)
6 Board of Trustees, Dane County Medical Society
6 Surgical Staff, Madison General Hospital
6 Madison Urological Society
6 Madison Anesthesiology Society
7 Planning Committee, Wisconsin Work Week of Health Program (Madison)
8 Commission on Public Policy
8 Madison Radiology Study Group
10 Wisconsin Society of Pathologists
11 President's Reception
11 Planning Committee, Council (Madison)
12 Medical & Surgical Foundation, Madison General Hospital
13 Board of Directors, National Association of Accountants
15 Planning Committee, In-Depth Teaching Program
18 Annual Meeting, American Medical Association (Atlantic City, N. J.)
19 Annual Meeting, AMA (Atlantic City, N. J.)
20 Annual Meeting, AMA (Atlantic City, N. J.)
21 Annual Meeting, AMA (Atlantic City, N. J.)
22 Annual Meeting, AMA (Atlantic City, N. J.)
24 Study Committee, Maternal Mortality Survey
28 Committee on Occupational Health
29 Wisconsin Association of Professions, Inc.
29 Vision Screening Committee
29 Educational Committee, Section on Ophthalmology
29 Division on Vision

Meetings not held in the Society "Home" but have a direct relationship are printed in italics, with the location in parentheses.

"Heartening" Acceptance by Speakers for Fifth Annual Wisconsin Work Week of Health, Oct. 16–20

The chairman of the Council, Dr. James C. Fox, of La Crosse, reports a heartening rate of acceptance by speakers from Wisconsin and across the nation who have been invited to take part in the fifth annual Wisconsin Work Week of Health at the State Medical Society headquarters in Madison, October 16–20.

The program, formulated by various units of the Society, under the direction of the Executive Committee of the Council, will again be open to the public as well as to medicine and its allies.

Each day's schedule will emphasize a particular subject, with speakers and panels covering many aspects of the topic of the day.

Themes for each day of the 1967 program are:

Monday, Oct. 16: Medical Aspects of Traffic Safety.

Tuesday, Oct. 17: Special Medical and Operational Problems in Nursing Home Administration.

Wednesday, Oct. 18: Scientific, Philosophical and Ethical Considerations in Life Extension.

Thursday, Oct. 19: The Role of Women in Health Careers.

Friday, Oct. 20: Community Resources in Rehabilitation of the Mentally Ill and Retarded.

Among speakers whose participants is confirmed are: Richard C. Dillihunt, M.D., Portland, Me., authority on motorcycle injuries; Dale Jennerjohn, Wisconsin State Board of Health; John D. Porterfield, III, M.D., Chicago, Ill., director of the Joint Commission on Accreditation of Hospitals; J. Ernest Breed, M.D., Chicago; John A. Spittell, Jr., M.D., Mayo Clinic, Rochester, Minn.; Mr. E. J. Holman, director of the AMA's Department of Medical Ethics; John B. Toussaint, M.D., clinical director of Central Wisconsin Colony and Training School, Madison; William W. Stead, M.D., Milwaukee Institutions; Hans O. Mauksch, Ph.D., dean of Liberal Arts, Illinois Institute of Technology, Chicago; Leonard L. Stein, M.D., chief of Medical Service, Mendota State Hospital, Madison; John Rankin, M.D., University of Wisconsin Medical School; and Rose Marie Chioni, Ph.D., R.N., assistant professor of nursing, University of Wisconsin, Madison.

Society President, Dr. Harold J. Kief, recently stressed the importance of membership attendance at Wisconsin Work Week of Health. "We are the only state medical society in the nation to present an annual program of this sort," Doctor Kief said. "Last year, we had an attendance of over 2,000, so it is obvious that our allies in health care are paying increasing attention to the benefits of this event.

"It will be a great day when physicians from the entire state reflect their pride in the meeting and concern for its success by arranging to be here for as much of the week as is possible."

MUSEUM AT PRAIRIE DU CHIEN A POPULAR TOURIST ATTRACTION

Mountain climbing equipment used by a woman physician from Wisconsin when she scaled the Himalayas; an audio display which lets the listener "experience" degrees of hearing loss; and a complete drug store from the late 1800s are among 6,500 square feet of exhibits in the Museum of Medical Progress at Prairie du Chien.

Owned and operated by the Charitable, Educational and Scientific Foundation of the State Medical Society, the three-building Museum complex is located on the site of the old Fort Crawford, a military post built in 1829. The Museum itself is housed in what was the fort hospital, and one wall, known as "Andy Jackson's wall" is the original. Through its windows General Jackson, when stationed there looked out over the camp.

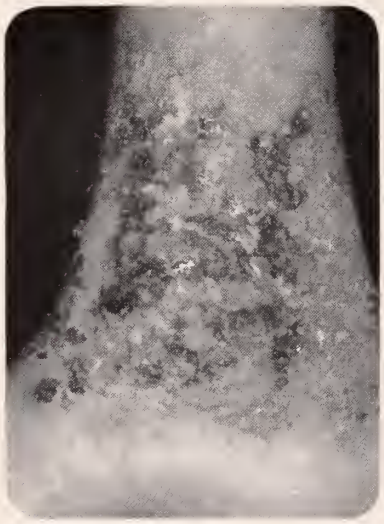
While flood waters came close this year, they failed to reach the high of 1965 which brought the Mississippi within feet of the lowest building, Stovall Hall of Health. That year the old hospital was again put into medical use; displays were pushed aside and Prairie du Chien residents filed in for tetanus shots. The hospital had originally been set on low ground, but was moved higher by military engineers in the 1830s, according to curator Gordon Peckham.

Last year over 23,000 visitors to the Museum traced the history of medical progress in Wisconsin and the midwest, from Indian folklore through the days of the "doctors on horseback," who mixed their prescriptions from herbs carried in their saddle bags ("the nastier the taste, the quicker the cure" one of them observed), to 20th century medicine which promises a healthy life expectancy of 75 years to a child born today in Wisconsin.

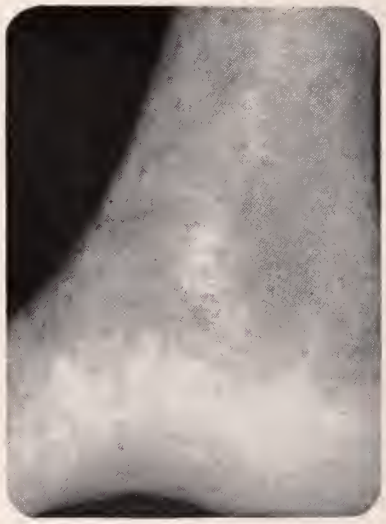
This season Mrs. Florence A. Bittner has been added to the staff as consulting curator. Mrs. Bittner is well known to Prairie du Chien visitors, having been curator of Villa Louis for the past 17 years.

The Museum is open seven days a week through October 31.

Eczema of many years... controlled in two weeks



Before treatment



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Contraindications: Tuberculosis of the skin, herpes simplex, chicken pox and vaccinia.

Precautions and Side Effects: Do not use in the eyes or in the ear (if drum is perforated). A few individuals react unfavorably under certain conditions. If side effects are encountered, the drug should be discontinued and appropriate measures taken. Use on infected areas should be attended with caution and observation, bearing in mind the potential spreading of infection and the advisability of discontinuing therapy and/or initiating antibacterial measures. Generalized dermatological conditions may require systemic corticosteroid therapy. Steroid therapy, although responsible for remissions of dermatoses, especially of allergic origin cannot be expected to prevent recurrence. The use over extensive body areas, with or without occlusive nonpermeable dressings, may result in systemic absorption. Appropriate precautions should be taken. When occlusive nonpermeable dressings are used, miliaria, folliculitis and pyodermas will sometimes develop. Localized atrophy and striae have been reported with the use of steroids by the occlusive technique. When occlusive nonpermeable dressings are used, the physician should be aware of the hazards of suffocation and flammability. The safety of use on pregnant patients has not been firmly established. Thus, do not use in large amounts or for long periods of time on pregnant patients.

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NEWS OF WISCONSIN PHYSICIANS

Dr. Lifson Receives Honor

Dr. Bernard I. Lifson, Skokie, Ill., recently was elected president of the Wisconsin Medical Alumni Association. Doctor Lifson graduated from the University of Wisconsin Medical School in 1949.

Dr. Burns Receives Teaching Award

Dr. Robert O. Burns, associate professor of medicine at the University of Wisconsin Medical School, has been selected as the 1967 recipient of the Wisconsin Medical Alumni Association's award for distinguished teaching. Doctor Burns, a member of the medical staff at Veterans Administration Hospital, was chosen for the award by senior medical students at the Medical School.

Dr. Nebel Guest Speaker

Dr. John R. Nebel, Menasha, recently was the guest speaker at the annual spring banquet of the Kaukauna Homemakers clubs. Doctor Nebel spoke on the subject "Mental Relaxation" and explained how it was first used in operations before anesthetics were produced.

Dr. Mangos Uncovers Clue in Research

Dr. John F. Mangos, Madison, pediatrician of the University's Cystic Fibrosis Center, recently discovered a "significant clue" in the search for the cause of cystic fibrosis. He discovered that sweat and saliva from children with the disease cause rats to excrete saliva with a high salt content. Because children with cystic fibrosis excrete abnormally high amounts of salt in their sweat and saliva it is one of the most important ways of diagnosing the disease.

Dr. Meis Speaks to Catholic Nurses

Dr. Paul Meis, La Crosse specialist in obstetrics and gynecology, recently gave a talk on "Treating the RH Mother and Unborn Child" before the La Crosse chapter of Catholic nurses. Doctor Meis graduated from the Iowa State University Medical School and is on the staff of St. Francis Hospital and the La Crosse Clinic.

Dr. Tenney Guest Speaker at Watertown

Dr. H. Kent Tenney, emeritus clinical professor of pediatrics, University of Wisconsin, and a past president of the State Medical Society, recently gave a lecture on "Changing Patterns of Pediatric Thought" at the spring conference of The Wisconsin Association for Childhood Education held in Watertown. Doctor Tenney is currently director of the State Medical Society's radio program "March of Medicine."

Marshfield Doctors Receive Appointments

Dr. Francis Kruse, Jr. has been reappointed by the State Board of Health to the Advisory Committee to State Alcoholism Services. During the past year Doctor Kruse has served on the committee's legislative and finance subcommittee. The State Medical Society reported that *Dr. Gail H. Williams* has been reelected to its committee on Cancer and *Dr. John J. Suits* has been reelected chairman of the Division on Handicapped Children of the Commission on State Departments.

Dr. Waskow Guest Speaker

Dr. William Waskow, Madison, recently was the guest speaker at the Oregon Rotary Club. Doctor Waskow spoke on the important work that x-ray plays in the detection and treatment of many human ailments. He is a radiologist associated with the Jackson Clinic.

Dr. Hickey Elected to Surgical Association

Dr. Robert C. Hickey, Madison, has been elected to the American Surgical Association. The association recently held its meeting in Colorado Springs, Colo., and Doctor Hickey was the eighth UW surgeon ever to be elected to the association.

Dr. Schwei President of Medical Staff

Dr. George P. Schwei, Neenah–Menasha, has been elected president of the medical staff of Theda Clark Memorial Hospital. He succeeds *Dr. David M. Regan.* Doctor Schwei, a fellow in the American College of Surgeons and the Wisconsin Surgical Society and certified by the American Board of Abdominal Surgeons, received his medical degree from Marquette University School of Medicine. The new vice-president, *Dr. Ralph L. Suechting,* took his medical training at Columbia College of Physicians and Surgeons and is certified by the American Board of Neurological Surgery and the Central Neurosurgical Society. *Dr. Frederick G. Jensen* is the secretary and received his medical training at New York University and has taken special courses in medicine and surgery at the University of Minnesota.

Dr. Fenlon President of Appleton Board of Health

Dr. C. E. Fenlon, Appleton, recently was elected to the presidency of the Appleton Board of Health. He succeeds *Dr. Carl D. Neidhold* who has served on the board for the past 35 years. Doctor Neidhold was presented with an inscribed public service plaque by the council for his continuous service on the board.

Physicians whose names appear in italics are members of the State Medical Society.

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PHYSICIAN NEWS *continued*

Dr. Eichman Master of Ceremonies

Dr. Peter L. Eichman, dean of the University of Wisconsin Medical School, was the master of ceremonies at the annual recognition program for interns and residents at the University of Wisconsin Hospitals. Dr. Leon O. Jacobson, dean of the Division of Biological Sciences at the University of Chicago and noted researcher in nuclear medicine was the guest speaker. Dr. John H. Greist, resident in medicine, received a $500 award for distinguished teaching from the Wisconsin Medical Alumni Association and was selected for this honor by his senior medical students.

Dr. Hellmuth Guest Speaker

Dr. George A. Hellmuth, director of the Marquette University School of Medicine and Curative Workshop of Milwaukee Cardiac Work Classification Unit, recently spoke to the Negligence Section of the State Bar Association of Wisconsin at Lakelawn Lodge, Delavan. Doctor Hellmuth's topic was "Attorney Attitudes on Medicolegal Aspects of Cardiac Cases Under the Workmen's Compensation Act of Wisconsin."

Doctor Prouty at the Museum

Photo courtesy PRAIRIE DU CHIEN COURIER–PRESS

DR. MARGARET PROUTY *of Madison examines some of her personal equipment which is on display at the Museum of Medical Progress and Stovall Hall of Health, Prairie du Chien. The exhibit, on health and recreation, has just been completed. Doctor Prouty is a renowned mountain climber and traveler who has been on expeditions to some of the highest mountains in the world. A pediatrician for 38 years, Doctor Prouty is planning to join a group on tour of a series of South American mountains this winter.*

Dr. Wochos Returns Home After Volunteer Service

Dr. Robert Wochos, Green Bay, recently returned from two months of volunteer service aboard the S. S. HOPE. The hospital ship trains medical per-

sonnel in every foreign port she visits, and her staff is now 130 physicians, nurses, technicians and dentists, many of them permanent. With the help of rotating physicians, the staff of the S. S. HOPE has performed 9,000 operations, treated 100,000 patients and immunized more than a million persons. Doctor Wochos spent a month of his tour on shore in Cartagena, Colombia, at the university hospital.

First Negro Graduate of UW Medical School

Photo courtesy THE CAPITAL TIMES

THE FIRST NEGRO TO RECEIVE a doctor of medicine degree from the University of Wisconsin is Walter J. Tardy of Madison, shown with UW President Fred H. Harrington who made the presentation at ceremonies June 5.

Dr. Currie Certified in Specialty Field

Dr. Robert E. Currie, Racine, recently was certified in the specialty of anesthesiology by the American Board of Anesthesiology. Doctor Currie graduated from the University of Colorado Medical School and his residency training was taken in Los Angeles.

Dr. Chisholm Volunteer MD in Vietnam

Dr. Tom Chisholm, Arcadia, recently spoke before the Chippewa Falls Kiwanis Club after two months as a volunteer physician in a civilian hospital in Vietnam. He presented his personal view on the problems in Vietnam and showed slides of several cases he treated and samples of the wide variety of diseases that prey on the Vietnamese.

A former Chippewa Falls physician, Doctor Chisholm also spoke to the McDonell Alumni Association June 3 at Chilppewa Falls. He strongly spoke out against the Vietnam war and decared that "the war must end in Vietnam" so that we may regain our humility, perspective, and prestige. He described the type of Americans in Vietnam and praised them as being the finest and most dedicated Americans he had ever met. He cited several reasons for the American presence in Vietnam.

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Photo by JESS SCOTT

DR. ELIZABETH COMSTOCK, now retired and a resident of Memorial Home, Neillsville.

Doctor Comstock's Career Reviewed

The life and career of one of Wisconsin's most revered physicians, *Dr. Elizabeth Comstock,* were recently featured in the LA CROSSE TRIBUNE by special correspondent, Jess Scott, a retired assistant postmaster of Neillsville.

Doctor Comstock has retired from active practice and now resides at Memorial Home in Neillsville.

Mr. Scott's article begins: "Dr. Elizabeth E. Comstock, a native of Arcadia, and for 65 years a general practitioner, physician and surgeon, looks back on a lifetime of service and wishes that she could continue to serve her fellow man. At the age of 91 . . . A lady of refinement and recognized as an outstanding physician, she reaches back 74 years to the beginning of her medical studies to reminisce of her career."

And ends: ". . .: A student, a reader, a lady of recognized ability in many fields of endeavor, Doctor Comstock still has her little satchel with a stethoscope and equipment for reading blood pressure, but they are no longer used on patients. They are merely to remind this successful doctor of 65 years of professional service in the field of medicine."

Dr. Larson Introduces Health Film

Dr. Craig Larson, Milwaukee, recently introduced a film and gave a short talk on the growth and development of boys in their early adolescence. The Muskego Women's Club and the Muskego Health Council sponsored the program.

Dr. Pawsat Guest Speaker

Dr. E. H. Pawsat, Fond du Lac, recently spoke before the meeting of the Rotary Club. Doctor Pawsat, speaking on the changing image of the physician and the practice of medicine, stated, "Our nation's No. 1 health need is more trained medical personnel." He also stated that the doctor shortage is acute and is being complicated by the disappearance on the medical scene of the general practitioner just at the time when our expanding national health programs are creating a new demand for the personal family physician. Doctor Pawsat is a former city health officer and has practiced in Fond du Lac for 34 years.

Dr. Bayley Honored for Boy Scout Work

Dr. Howard G. Bayley, Jr., Beaver Dam, recently was honored at a testimonial banquet for seventeen years of leadership services to the Boy Scouts. Doctor and Mrs. Bayley were presented with gifts and testimonial letters written by former scouts.

Greenwood Physician Featured

Featured in the June issue of the WISCONSIN SCHOOL BOARD NEWS is an article describing the contribution of *Dr. William A. Olson,* Greenwood, to a unique health program in Greenwood schools. Each week Doctor Olson donates a half day to serving the Greenwood schools as a professional assistant in the special health program. All school children in the community, public and private, are included in the program.

The program includes such services as physical examinations for students and athletes, eye and ear examinations, maintenance of complete pupil health records, and counseling on pupil health programs. In the report published in the WISCONSIN SCHOOL BOARD NEWS, Doctor Olson said that he appreciates the opportunity to extend greater health services to the Greenwood area children for it was he "who brought most of them into the world."

Doctor Radl Discusses Eye Diseases

Diseases of the eye were discussed by *Dr. C. L. Radl* of Manitowoc at the June 5 meeting of the Daughters of Isabella at the Veterans Club in Manitowoc.

Doctor Burris Mental Health President

Dr. B. Cullen Burris was reelected president of the Milwaukee County Association for Mental Health at the association's annual meeting in May at the Milwaukee Inn.

Award to Dr. Virginia Downes

At the Milwaukee Municipal Woman's Club Annual Awards Dinner in May, *Dr. Virginia S. Downes* was awarded the Alice Paukner Perch Memorial Award.

Photo courtesy SUPERIOR EVENING TELEGRAM

A "JACK BENNY" BIRTHDAY. Staff members of the Superior Memorial Hospital on May 18 honored *Dr. Henry A. Sincock* on his 81st birthday by presenting him with a birthday cake and dedicating the hospital's publication, MEMORIAL MEMO'S, to him. Mrs. Lois Boone, left, a registered nurse at the hospital was delivered at birth by Doctor Sincock at St. Francis Hospital, now a rest home. Miss Esther Nelson, director of nursing at the hospital, and Mrs. Nancy Larson, dietitian, are at the right. A number of other employees of the hospital were also delivered by Dr. Sincock. In the special edition of MEMORIAL MEMO'S it was stated: "This edition of the MEMORIAL MEMO'S is proudly dedicated to a man of medicine and a man among men who has continued to give of himself unselfishly and untiringly his knowledge, ability, and consideration, to all with whom he has had contact through the years."

New Doctor Receives Merit Award

Dr. Robert A. Cordes, a June medical student graduate, was the recipient of the 1967 National Foundation merit award for the best paper on birth defects written while he was a senior student at Marquette University School of Medicine, Milwaukee.

The award check of $250 was presented at the March of Dimes annual awards dinner, June 8 at the Milwaukee Athletic Club.

Doctor Cordes of Wauwatosa is a 1959 graduate of Marquette University high school and received his bachelor of science degree from Marquette University in 1963. He is taking his internship training at the Johns Hopkins Hospital, Baltimore.

Dr. Quackenbush Appointed to Staff

Dr. Robert P. Quackenbush has been appointed to the home office staff of Northwestern Mutual Life Insurance Co., Milwaukee, as Assistant Medical Director. Doctor Quackenbush graduated from the University of Illinois Medical School and is a member of the American Academy of General Practice.

Dr. L. C. Pomainville New Grandpa

The Pomainville family may be starting another generation of physicians. Dr. and Mrs. Philip Hacker of Stevens Point have announced the birth of a son, Leland Pomainville Hacker, in June. Mrs. Hacker is the former Ann Pomainville, daughter of *Dr.* and Mrs. *Leland Pomainville* of Wisconsin Rapids.

Dr. Marks Receives Ohio Appointment

Dr. Charles Marks, associate professor of surgery at Marquette University School of Medicine, chief of a surgical section at County General Hospital and surgical consultant at the V. A. Hospital at Wood, has been appointed director and chief of surgery at Cleveland's Mount Sinai Hospital Medical School,

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as well as clinical professor of surgery at Western Reserve University Medical School, attending surgeon at University Hospitals, consultant surgeon at the V.A. and Cleveland State Hospitals.

Doctor Marks graduated in medicine from the University of Cape Town Medical School in 1945, and also holds an M.S. degree in Surgery obtained at Marquette University. He is a member of the Royal College of Physicians and a fellow and former Hunterian professor of surgery of the Royal College of Surgeons of England. Doctor Marks spent ten years in surgical practice in South Africa at which time he helped found the South African College of Surgeons and founded and edited the CENTRAL AFRICAN JOURNAL OF MEDICINE. He joined the Marquette faculty in 1963 and has been the author of many surgical papers, as well as a contributor to surgical textbooks.

Dr. Farrington Urges Rescue Worker Training

Dr. J. D. Farrington, Woodruff, has enlisted the help of his fellow townsmen to cope with the vehicular accidents that occur in the summer resort communities in the northwoods. Doctor Farrington says that "physicians have a responsibility to protect accident victims from further injury by teaching rescue workers the appropriate techniques of their job." He describes these techniques in an article, "Death in a Ditch," which is in the May–June issue of the BULLETIN OF THE AMERICAN COLLEGE OF SURGEONS. Doctor Farrington helped to train nonmedical personnel assigned to rescue units in the correct methods of handling injured persons in Chicago before coming associated with the Lakeland Memorial Hospital in Woodruff.

Dr. Hayden Guest Speaker

Dr. John W. Hayden, La Crosse, recently spoke before the La Crosse Industrial Safety Council on back injuries. Using slides, Doctor Hayden explained many kinds of orthopedic injuries people suffer on and off the job.

Dr. Sorensen President of Medical Staff

Dr. R. F. Sorensen, West Bend, was elected chief-of-staff of St. Joseph's Community hospital. Other officers are Dr. J. H. Schultz, vice-president, and *Dr. J. E. Albrecht*, secretary–treasurer. Members of the executive committee in addition to the officers are *Dr. W. A. Nielsen*, *Dr. A. T. Grundahl*, and *Dr. F. I. Bush*.

Dr. Tobin Guest Speaker at Lions Club

Dr. Joseph Tobin, Eau Claire, recently discussed Eau Claire's suicide prevention center before members of the Lions Club. Doctor Tobin stated, "that the center has been responsible for saving several lives since it opened a year ago." Doctor Tobin is a staff member of the Northwest Psychiatric Clinic in Eau Claire.

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Dr. Shields Guest Speaker

Dr. John Shields, La Crosse, recently was the guest speaker at the Jaycettes monthly meeting. Doctor Shields spoke on the topic of "The National Movement Opposed to Organized Mental Health Programs."

Dr. Siebert Elected to Academy

Dr. John T. Siebert, Baraboo, has been elected to active membership in the American Academy of General Practice. Founded in 1947, the AAGP is the country's second largest national medical association.

Dr. Kief Speaks at Dedication

Dr. H. J. Kief, Fond du Lac, president of the State Medical Society, recently spoke at the dedication ceremonies of the J. S. Kemper Clinic at Ripon Collge. Doctor Kief praised the role of private contributions in the building of the clinic and stated that "modern medicine and education should follow the voluntary way, not the government way of funding improvements."

Dr. Heywood Guest Speaker

Dr. William H. Heywood, Marshfield, recently spoke before the opening session of the 52nd annual conference of the Wisconsin Council of Catholic Women in Stevens Point. Doctor Heywood spoke on the overprotected child of today, and related, "that too many children have had things done for them and have never been able to cope with problems."

UW Doctors Discuss Organ Transplants

Faculty members from the University of Wisconsin, Madison, recently took part in a discussion before the alumni of the Wisconsin Medical School, on the transplantation of organs. Drs. *William P. Young,* Fritz H. Bach, *William A. Kisken, Arvin B. Weinstein,* and *Richard E. Rieselbach* took part in the panel. The program also included the dedication of the new Middleton Library, named for *Dr. William S. Middleton,* emeritus dean of the Medical School.

Dr. Porter Attends Workshop

Dr. Gerald Porter, Marshfield, participated in an all-day workshop on "The Abused and Battered Child" which was held at the University of Wisconsin–Green Bay Center. Doctor Porter, a pediatrician at Marshfield Clinic, illustrated with slides a presentation on medical recognition of abused children.

Doctor Graven Attends Meeting

Dr. Stanley Graven, Madison, professor of pediatrics at the University of Wisconsin, attended a physicians and nurses meeting on the "Care and Treatment of Newborn Infants" in Eau Claire. Talks were given by Doctor Graven and *Dr. Gertrude Howe,* director of community health services for the State Board of Health.

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Doctors Honored on Alumni Day

At the University of Wisconsin Medical Alumni Day banquet held in Madison at the Park Motor Inn May 26, Dr. Elmer L. Severinghaus, Madison, and *Dr. Hans H. Reese*, Madison, received the Alumni Association's Citation and the Emeritus Faculty Award, respectively.

Dr. Samuel Harper With CUNA Society

Dr. Samuel B. Harper has been appointed vice-president and medical director of CUNA Mutual Insurance Society, Madison, effective June 1, according to an announcement by Charles F. Eikel, Jr., CUNA Mutual president. Doctor Harper fills the position left vacant last December by the death of Dr. E. M. Juster, the Society's first medical director.

Doctor Harper has been a Madison physician and surgeon for the past 20 years. He has been associated with *Doctors I. R. Sisk, William B. Hobbins, H. K. Parks*, and the late R. T. Cooksey.

Doctor Harper, who recently returned from a tour of volunteer duty in a South Vietnam hospital, has spent most of his life in Madison. He graduated from the University of Wisconsin Medical School in 1937. Following graduation, Doctor Harper was associated with the Mayo Clinic at Rochester, Minn., from 1938 to 1943, when he also received a master's degree in surgery from the University of Minnesota.

During World War II, from 1943 to 1946, Doctor Harper served as a surgeon with the Army in the South Pacific. He returned to practice in Madison after the war.

His father, the late Dr. C. A. Harper, was a well known Madison physician and served as State Health Officer for many years.

Dr. Frank Larson to Europe

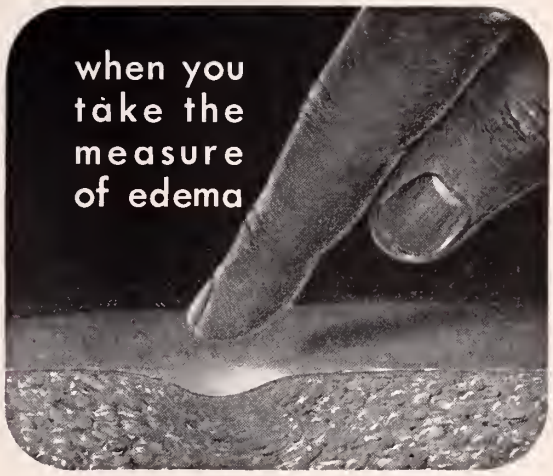
Dr. Frank Larson, professor of medicine and director of the clinical laboratories, University of Wisconsin Medical Center, left June 8 for Europe where he will spend six to eight weeks in Holland, England, and Sweden, studying the operation of clinical laboratories, with particular reference to automation and computer processing of data.

Doctor Liebenow Retiring

Dr. R. R. Liebenow, Lake Mills physician since 1950, will be closing his office the latter part of August for health reasons. He plans to continue living in Lake Mills and expects to continue in administrative medical work.

Doctor Headlee Heads Medical Staff

Dr. Charles Raymond Headlee of Wauwatosa has been elected president of the medical staff of Milwaukee Psychiatric Hospital, Wauwatosa, and *Dr. Reynold A. Nocella*, also of Wauwatosa, has been elected secretary-treasurer. Each election is for a one-year term. Their predecessors are *Drs. William L. Lorton* and *Laszlo Varga* of Wauwatosa.



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DOSAGE: Diuresis, initially 50 to 200 mg.; maintenance 25 to 150 mg., daily. Hypertension 50 to 100 mg. initially, adjusted to 50 mg. t.i.d. or downward to minimal effective dosage level.

WARNINGS: Use with caution in the presence of renal disease as azotemia may be precipitated or increased. In patients with advanced hepatic disease, electrolyte imbalance may result in hepatic coma. Dosage of coadministered antihypertensive agents should be reduced by at least 50%. In cases of suspected electrolyte imbalance, serum electrolyte determinations should be performed and imbalance, if any, corrected. Stenosis or ulcer of small intestine have been reported with coated potassium formulas, and surgery has been required and deaths have occurred. Based on surveys of both United States and foreign physicians, incidence of these lesions is low and a causal relationship in man has not been definitely established. Until further experience has been obtained, the use of the drug in pregnant patients should be weighed against possible hazards to the fetus.

CONTRAINDICATIONS: AQUATAG (benzthiazide) is contraindicated in progressive renal disease or dysfunction including increasing oliguria and azotemia. Continued administration of this drug is contraindicated in patients who show no response to its diuretic or antihypertensive properties. Severe hepatic disease is a relative contraindication. (See "Warnings" above.)

PRECAUTIONS AND SIDE EFFECTS: Electrolyte imbalance with hypokalemia (digitalis toxicity may be precipitated), hypochloremic alkalosis and hyponatremia may occur.

Patients with cirrhosis should be observed for impending hepatic coma and hypokalemia. Other reactions may include blood dyscrasias, hyperuricemia and gout, nausea, jaundice, anorexia, vomiting, diarrhea, dizziness, paresthesia, photosensitivity and headache. Hepatic fetor, tremor, confusion and drowsiness are signs of impending pre coma and coma in patients with cirrhosis. Insulin requirements may be altered in diabetes. AQUATAG (benzthiazide) should be used with caution post-operatively as hypokalemia is not uncommon. Potassium supplementation may be advisable pre- and post-operatively. There have been occasional reports of thrombocytopenia, leukopenia, agranulocytosis, aplastic anemia and precipitation of acute pancreatitis or jaundice.

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Dr. Stead Develops Model Lung

Models of inflated human lungs to depict various stages of tuberculosis for use in teaching and in helping patients to understand the nature of their disease have been developed by *Dr. William W. Stead*, a Milwaukee tuberculosis specialist. The lung models are life-size and molded of polyurethane foam.

Doctor Stead, who is professor of medicine at Marquette University School of Medicine, Milwaukee County General Hospital, for 18 years has been concerned with teaching medical students, interns, residents, nurses, and patients the nature and vagaries of tuberculosis.

Doctor Stead believes that his lung models depicting tuberculosis are only the beginning of the use of this medium in teaching students and communicating with patients. He is currently working on models to simulate diseases such as emphysema and cancer.

The Bostrom Corporation of Milwaukee, pioneers in polyurethane foam development, as a contribution to medical science, has placed its research facilities at Doctor Stead's disposal.

Tomah Physician Honored

Dr. H. E. Wilkinson, director of the Tomah Veterans Administration Hospital, was honored at the annual meeting of the Greater Tomah Area Chamber of Commerce at the Holiday Lodge June 3. Doctor Wilkinson was cited for his interest and activity manifest in the welfare of the Tomah community. He was picked as the Chamber member who had rendered the greatest service to the community.

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You might also say that all interns aren't alike, either.

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Dr. McLeod Joins Jackson Clinic

Dr. Paul A. McLeod, a native of Madison, has joined the obstetrics and gynecology department of the Jackson Clinic in Madison. Doctor McLeod was graduated from the University of Wisconsin Medical School in 1960. After an internship at St. Luke's Hospital, Duluth, Minn., he served two years as a captain in the Air Force.

He completed his residency in obstetrics and gynecology at Columbia Presbyterian Hospital, New York City. Before joining the Jackson Clinic, he spent six months in the department of gynecology and obstetrics at University Hospitals, Madison.

Doctor Viel on Waukesha Hospital Staff

The Waukesha Memorial Hospital board recently appointed *Dr. Robert S. Viel,* Brookfield, to the temporary staff in the field of general practice. He replaces the late Dr. John P. Kelly of Pewaukee.

Dr. Gallagher on Vietnam Experiences

Dr. William B. Gallagher of La Crosse gave a slide-illustrated talk on his experience as a volunteer physician in Vietnam to members of the Rotary Club meeting at the Hotel Stoddard in La Crosse, June 1.

Doctor Morgan Speaks at Heart Forum

Dr. Sherburne F. Morgan, pediatric cardiologist of Milwaukee, spoke at a public forum sponsored by the Wisconsin Heart Association June 14 at Oconto Memorial Hospital.

Dr. Wagelie Beloit City School Physician

Dr. R. G. Wagelie recently signed a three-year contract as Beloit City School's physician. He succeeds *Dr. Frank Johnson* who will continue his studies at the University of Wisconsin.

Dr. Cohen Guest Speaker

Dr. David A. Cohen, Edgerton, recently was the guest speaker at the Janesville Newcomers Club. Doctor Cohen, who uses hypnosis in his practice, presented his talk on "Hypnosis and Medicine."

Dr. Meyer Appointed to Staff

Dr. Jules O. Meyer has been appointed to the home staff of Northwestern Mutual Life Insurance Co., Milwaukee, as Assistant Medical Director. Doctor Meyer retired from the Medical Corps of the regular U.S. Army in 1964 after 20 years of service. He received his medical degree from the University of Minnesota Medical School and is certified by the American Board of Preventive Medicine. During World War II he served with the 7th Infantry Division of the U.S. Army and returned to private practice in Grand Rapids in 1946. In 1949 he was commissioned a regular officer and served in Germany, Italy, and numerous posts throughout the U.S. until his retirement.

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Contraindications: Edema; danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia. The drug should not be given when the patient is senile or when other potent drugs are given concurrently.

Warning: If coumarin-type anticoagulants are given simultaneously, watch for excessive increase in prothrombin time. Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea, sulfonamide-type agents and insulin. Carefully observe patients receiving such therapy. Use with great caution in the first trimester of pregnancy.

Precautions: Obtain a detailed history and a complete physical and laboratory examination, including a blood count. The patient should be closely supervised and should be warned to report immediately fever, sore throat, or mouth lesions (symptoms of blood dyscrasia); sudden weight gain (water retention); skin reactions; black or tarry stools or other evidence of intestinal hemorrhage. Make regular blood counts. Discontinue the drug and institute countermeasures if the white count changes significantly, granulocytes decrease, or immature forms appear. Use greater care in the elderly and in hypertensives.

Adverse Reactions: The most common are nausea, edema and drug rash. The drug has been associated with peptic ulcer and may reactivate a latent peptic ulcer. Infrequently, agranulocytosis, or a generalized allergic reaction may occur and require withdrawal of medication. Stomatitis, salivary gland enlargement, vomiting, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported but cannot definitely be attributed to the drug. Thrombocytopenic purpura and aplastic anemia may occur. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hyperglycemia, hepatitis, jaundice, and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently. Moderate lowering of the red cell count due to hemodilution may occur.

Dosage in Osteoarthritis: The initial daily dosage in adults is 300-600 mg. in divided daily doses. When improvement occurs, dosage should be decreased to the minimum effective level; this should not exceed 400 mg. daily, and is often achieved with only 100-200 mg. daily.

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COUNTY SOCIETY PROCEEDINGS

Ashland–Bayfield–Iron

The Ashland–Bayfield–Iron County Medical Society met June 13 with their wives at the Platter in Ashland. Following dinner the women adjourned to another room for an Auxiliary meeting. President *Dr. Harold Guzzo* was in charge of the meeting. Two physicians from Duluth, Minn., spoke of the new multiple test machine for clinical medicine which was recently installed in St. Luke's Hospital, Duluth. The physicians stated that twelve tests are recorded from one blood specimen.

Barron–Washburn–Sawyer–Burnett

Dr. Robert Anderson of Cumberland was named president of the Barron–Washburn–Sawyer–Burnett County Medical Society at its annual meeting in May at the King Edward Inn, Rice Lake. Doctor Anderson succeeds *Dr. J. K. Hoyer* of Rice Lake. Other officers named are: *Dr. M. E. Gillespie* of Rice Lake, vice-president; and *Dr. D. G. McMillan* of Barron, secretary-treasurer.

Chippewa

The Chippewa County Medical Society met at Reiter's Steak House in Chippewa Falls June 6. The Society approved the sponsorship of a free measles clinic on June 28 at the Chippewa County Court House. The doctors offered their time so that a doctor could be present at all times. The clinic was conducted in cooperation with the county nurse.

Speaker for the evening was Dr. Weldon Shelp of the Department of Medicine, University of Wisconsin Medical School, Madison. He spoke on "Chronic Renal Failure" and stressed the conservative management of renal failure. He also discussed dialysis and renal transplantation.

Dane

"Big Game Hunting in Africa" was the topic for the evening at the June 13 meeting of the Dane County Medical Society, held at Hoffman House West, Madison. Leo Roethe of Nasco Industries, Fort Atkinson, was the speaker.

Milwaukee

Plans for a Society-sponsored Health Career Fair were approved at an April meeting of the Public Relations Committee of The Medical Society of Milwaukee County. It was agreed that attendance be promoted in the Greater Milwaukee area, including surrounding counties, and possibly the entire southeastern Wisconsin area. In other action, the Committee agreed to implement Community Health Week with a program about air pollution.

Racine

Dr. Beverly C. Payne of Ann Arbor, Mich., spoke to members of the Racine County Medical Society at its May meeting. He also spoke at an afternoon symposium for hospital administrators who are members of the Southeast Council and the Milwaukee Hospitals Council. Both meetings were held at the Johnson Foundation's Wingspread Conference Center.

Doctor Payne, an authority on the most efficient use of hospital resources, is assistant dean in the School of Medicine, University of Michigan; past president of the Michigan Society of Internal Medicine; and a past board member of Michigan Blue Shield. He also has a private practice in internal medicine.

Rock

The April 28 meeting of the Rock County Medical Society was held at the Hilton Hotel in Beloit. Speaker for the evening was Philip R. Smith, assistant vice-president and trust officer of the First National Bank, Madison. His subject was "Problems of Joint Tenancy and Inheritance Taxes."

In other matters, the 24 members present discussed the report of the osteopathic committee and adopted changes to the Bylaws.

Walworth

Dr. John Sadd, chief resident in plastic surgery, University of Wisconsin Medical Center, Madison, spoke to members of the Walworth County Medical Society April 20 on the subject "Treatment of Facial Bone Injuries and Face Lacerations." Discussants were Doctors *W. C. Woods, R. S. Galgano, K. C. Bill, R. D. Petersen, O. G. Bingol, D. R. Hansen, J. B. Schrock, R. J. Rogers*, and *H. F. Bischof*. Twenty-three members, wives and guests attended the meeting at the Sterlingworth Motel in Elkhorn.

The May 18 meeting of the Walworth County Medical Society was held at the Rondo Manor in Delavan with 25 members and guests in attendance. William Broik of the First National Bank of Madison addressed the group on "Retirement Programs for the Self-employed."

Winnebago

Earl R. Thayer, secretary of PACE, spoke at the monthly meeting of the Winnebago County Medical Society June 1 at Robbins Restaurant, Oshkosh.

* * *

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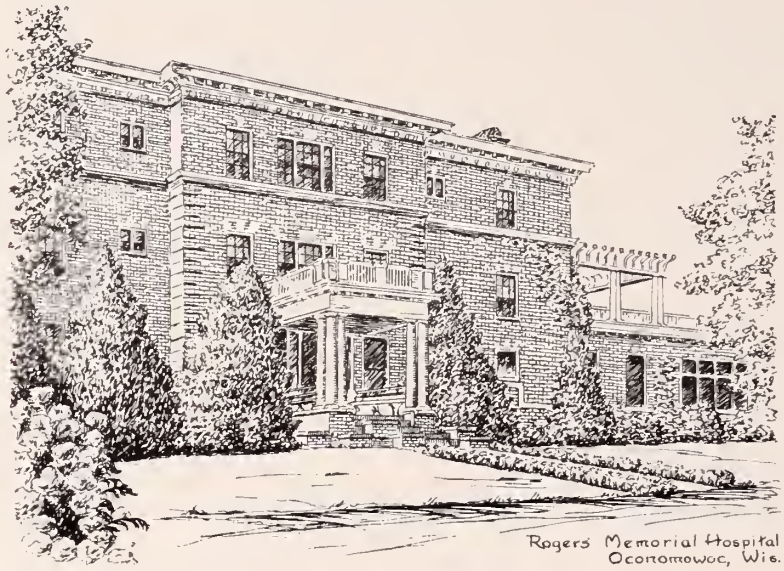
Physicians whose names appear in italics are members of the State Medical Society.



MEDICAL STAFF

OWEN OTTO, M D
Medical Director
EUGENE B. FRANK, M D
LOREN J DRISCOLL, M. D
THOMAS J GORAL, M. D
JOHN J O'HARA, M D
EARL F WEIR, M D
LEROY WAUCK Ph D
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ROBERT TESTIN Ph D
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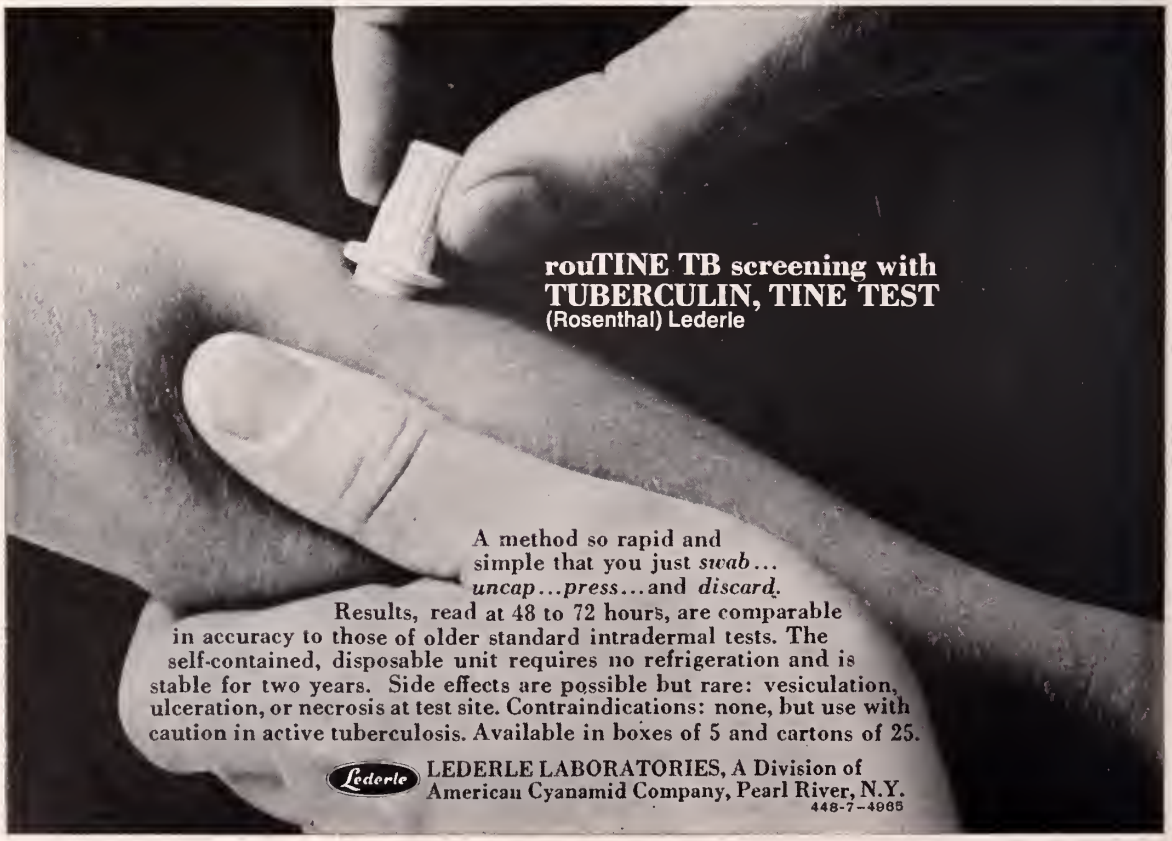

Madison Academy of Internal Medicine

The May 15 meeting of the Madison Academy of Internal Medicine was held at the State Medical Society headquarters in Madison. Dr. D. J. McCarty of Hahnemann Medical School lectured on "Current Concepts in Gout." At the annual business session the following officers were elected: *Dr. Charles A. Doehlert, Jr.*, president; *Dr. Paul O. Simenstad*, president-elect; *Dr. D. William Hurst*, secretary; and *Dr. D. U. Cookson*, treasurer.

Wisconsin–Upper Michigan Society of O–O

A scientific meeting, arranged by Marquette University School of Medicine, Milwaukee, was presented June 10–11 by the Wisconsin–Upper Michigan Society of Ophthalmology and Otolaryngology at Milwaukee County Hospital and Wood Veterans Administration Center.

The June 10 program at Milwaukee County Hospital included the following participants and their topics: *Dr. O. A. Weigmann*, "Variability of Squin Measurements;" Drs. *R. O. Schultz* and *H. A. Easom*, "Unknowns in External Eye Diseases;" Drs. E. B. Suson and *T. R. Sawyer*, "Evaluation of Various Glaucoma Tests;" Doctor Sawyer, "Office Perimetry;" and *Dr. D. P. Nachazel, Jr.*, "Examination of the Retina."

In the evening a dinner party was held at the Hotel Pfister. Ken Haagenson, executive vice-president of the Wisconsin State Chamber of Commerce, addressed the group on "Are Our Messages Getting Through?".

The program on June 11 was held at the VA Center with the following participants and their topics: *Dr. Meyer S. Fox*, "The Industrial Noise Problem, Twenty Years Later;" *Dr. Charles J. Finn*, "Injuries to Nasal Cartilages;" *Dr. P. A. Sciarra*, "Complications of Stapedectomy;" and *Dr. Anthony Grueninger*, "New Modalities of Radiation Therapy of Head and Neck Tumors."

Doctor Schultz, chairman of the Department of Ophthalmology, Marquette, moderated the June 10 program while *Dr. Roger Lehman* moderated the otolaryngology program on June 11. A tour of the facilities of the new VA Hospital concluded the meeting.

Physicians whose names appear in italics are members of the State Medical Society.

SPECIALTY SOCIETY PROCEEDINGS

Milwaukee Academy of Surgery

Members of the Milwaukee Academy of Surgery met June 26 at St. Luke's Hospital in Milwaukee. Participants and topics included: *Drs. John A. Walker*, "Cardiac Pacemaker," *Victor M. Bernhard*, "Aortic Vascular Surgery," and *Thomas M. O'Connor*, "Carcinoid of the Bronchus." A tour of the Hyperbaric Chamber was included.

Milwaukee Roentgen Ray Society

Dr. Harold F. Ibach has been selected president of the Milwaukee Roentgen Ray Society for 1967–1969. *Drs. Alan B. Fidler* and *James E. Bell* were named vice-president and secretary-treasurer, respectively.

Milwaukee Internists Club

Speaking before members of the Milwaukee Internists Club recently, *Dr. David M. Glassner*, a Milwaukee allergist, described the hazardous and even lethal effects resulting from continuous use of inhaled medication for the relief of asthmatic conditions. He cited two patients in Milwaukee who apparently died as a result of inhaler abuse. Drugs taken by mouth will produce highly effective dilation of the air passages without irritation, Doctor Glassner said.

Milwaukee Academy of Medicine

Members of the Milwaukee Academy of Medicine met May 16 at the University Club of Milwaukee for the 935th meeting of the group. Dr. David M. Kipnis, Professor of Medicine at Washington University School of Medicine, addressed the group on the "Studies of the Regulation of Insulation Secretion." Doctor Kipnis also attended Grand Rounds at the Milwaukee County General Hospital the next day.

QUARTERLY ON CEREBROVASCULAR DISEASE PUBLISHED

The Winter–Spring 1967 issue of *Stroke—Current Concepts of Cerebrovascular Disease*, is now available to physicians, hospitals and medical schools without charge from local Heart Associations.

This is the first issue of the publications sponsored directly by the American Heart Association. The quarterly publication was established in 1966 and previously issued by the New York State Heart Assembly.

The publication, intended to offer interesting and practical information to the medical practitioner, will continue to carry one or two short, pertinent articles on the subject of stroke in each of its four issues a year. Walter J. Friedlander, M.D. of Omaha, remains as editor.

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Dane County Mental Health Centers

The Dane County Mental Health Centers, along with Kansas University at Lawrence, were awarded a NIMH grant of $24,000 to complete a project on the "Family Concept Q-Sort and Improvement with Psychotherapy." The Family Concept Q-Sort includes a number of items which delineate attitudes and characteristics of any given family. It holds promise as a simplified measure for screening out parents who could be further evaluated to identify high-risk parents prone to develop an environment for their offspring conducive to emotional disorder. F. van der Veen, Ph.D., associate professor of psychology at the University of Kansas, developed and modified this measure with the Mental Health Centers' staff in Madison. The clinical aspect of the research has been done in Madison. Its completion may require the cooperation of psychiatric clinics with children as clients in other parts of the state.

Western Wisconsin Health Planning Group

A group of about 30 persons, representing industry, local government, hospitals, and medical clinics, met in Heileman Hall at La Crosse late in May to discuss plans of the Western Wisconsin Health Planning Organization. Its chairman, *Dr. Robert E. McMahon*, who is also director of health services at La Crosse State University, presided.

Dr. James M. Sullivan of Milwaukee, assistant coordinator of the Wisconsin Regional Medical Program, addressed the group. He noted that the "fortunate medical capability" of La Crosse obliges it to serve a wider area.

Obtaining funds from private and public sources to support the Western Wisconsin plan, including hiring an executive director, is one of the first goals, said Doctor McMahon.

Another goal in planning for future medical and hospital services, said Doctor Sullivan, is to avoid duplication "of any health facilities." Also, he said, the plan "strives for proper utilization of health manpower resources."

The authority from the federal government to set up a health planning organization is about one and a half years old. Little progress has been realized in the La Crosse area, it was pointed out.

Once a full-fledged program is underway, said Doctor McMahon, the locality raises 50 per cent of the funds and the federal government matches this.

The City of Milwaukee has a health planning organization. Progress has been made in Dane County, centering on Madison, and in Wausau. La Crosse is the fourth similar group in Wisconsin.

The regional plan could encompass an area larger than Wisconsin, Doctor Sullivan said.

Milwaukee Medical Center Discussion

An educational conference to discuss the proposed medical center for Milwaukee was planned for this month, possibly at Wingspread near Racine. Planners of the conference are members of the executive committee of the medical center steering committee. Physicians on the committee include *Drs. Harold F. Hardman*, professor and chairman of pharmacology at Marquette; *James M. Sullivan*, assistant coordinator of the Wisconsin Regional Medical Program; *Francis F. Rosenbaum*, and *Robert F. Purtell.*

A Milwaukee medical center with the Marquette University School of Medicine and Milwaukee County General Hospital as its nucleus was proposed last January by the Greater Milwaukee Committee.

Physicians whose names appear in italics are members of the State Medical Society.

PARAMEDICAL ANCILLARY GROUPS

Free Nurse Instruction, Chippewa Hospital

St. Joseph's Hospital of Chippewa Falls on June 5 began a free month-long inservice training session, and refresher course and workshop for inactive registered nurses. A simultaneous training session was held in June for new nurses' aides and for persons now employed at St. Joseph's. The program got its start because a small town woman who grew tired of just sitting around the house placed an ad in the local newspaper inquiring whether any hospital in the area was seeking a registered nurse who also happened to have a master's degree in education.

After receiving replies from virtually "every hospital, nursing home, and institution in the area, Mrs. Anno Jordheim, wife of a Lutheran pastor in Bloomer, chose to work close at home and accepted employment at the 150-bed, 82-year old institution run by a Catholic order of nuns.

Vernon County Mental Health Association

Dr. Robert A. Starr of Viroqua spoke on "Sex Education in the Public Schools" in the Westby high school auditorium recently. Similar programs were also presented in Ontario, De Soto, and Hillsboro under the sponsorship of the Vernon County Mental Health Association which conducted its annual fund drive in May.

Portage County Association for Mental Health

Dr. Darold A. Treffert, superintendent of Winnebago State Hospital, Oshkosh, spoke at the Sentry Insurance Company auditorium in May under the sponsorship of the Portage County Association for Mental Health. Topic was "Psychiatry—Past and Future."

Green County Mental Health Group

The Green County Association for Mental Health and the Monroe PTA Council recently cosponsored

a panel discussion of the new morality found in today's society at the Monroe high school lecture hall. *Dr. Egbert Kamstra*, psychiatrist, and Tom Sampson, clinical psychologist, both of The Monroe Clinic, were members of the panel. The aim of the program was to provide guidelines for parents.

UW Medical Center Graduate Statistics

On Commencement Day, June 5, the following students at the University of Wisconsin Medical Center, Madison, received degrees: 92 medical students, 89 nursing students (B.S. degrees), 6 pediatric nursing students (M.S. degrees), 20 medical technology students (B.S. degrees), 24 physical therapy students (B.S. degrees), and 11 occupational therapy students (B.S. degrees).

Receiving certification were eight dietetic interns who then became full-fledged dietitians. Fifteen students received certificates as registered x-ray technicians.

There are also 91 interns and residents who are completing their programs in the Medical Center, and one pharmacy resident and one administrative resident who will finish their training this summer.

Heart Clinic at Superior

A congenital and rheumatic heart disease clinic was held recently at St. Mary's Hospital, Superior, sponsored by the Wisconsin Heart Association and the Douglas County Medical Society. *Dr. D. J. Freeman*, Wausau internist and a pediatrician from University Hospitals, *Dr. Thomas C. Meyer*, who also is assistant dean of the UW Medical School, examined about 25 patients who were referred to the clinic by their physicians.

The Heart Association also presented a certificate of merit to the SUPERIOR EVENING TELEGRAM "for outstanding service in advancing the heart program and stimulating public support in the fight against the diseases of the heart and circulation."

Certification in Blood Banking

Nils J. Slepekis, M.T. (ASCP) BB of St. Nicholas Hospital Blood Bank, Sheboygan, was recently certified in blood banking by the American Association of Blood Banks and the American Society of Clinical Pathologists after completing a year of training at an AABB Approved School and passing the comprehensive written and practical examinations conducted by the two groups.

St. Michael Hospital, 10th Anniversary

St. Michael Hospital, Milwaukee, celebrated the 10th anniversary of its opening with two special events in June. The first honored all employees who have been with the hospital for the past 10 years. A gala birthday party was held for all children born at the hospital during the first month it was opened in 1957 and on the "birthday" of the opening each year thereafter. These are the first of several observances and special projects to be held during the year, according to Sister M. Illumina, administrator.

Jackson Clinic Meeting

About 100 physicians from the Madison area attended the anual spring postgraduate meeting sponsored by the Jackson Clinic and Foundation of Madison May 24. The sessions were held at the Park Motor Inn. John E. Erickson, University of Wisconsin basketball coach, was guest speaker at the evening dinner.

Dr. Luther E. Holmgren, president of the Clinic and Foundation, welcomed the visitors. *Dr. John H. Morledge* and *Dr. William B. Parsons, Jr.* were chairmen of sessions which were divided.

Speakers at the first session were *Dr. H. C. Ashman*, "Meningitis;" *Dr. Allen J. Pois*, "Aortic Aneurysmus;" and *Dr. Paul A. McLeod*, "Induction of Ovulation by Drugs."

Speakers at the second session were Dr. Donald A. Scholz of the Mayo Clinic, "Toxic Cerebral States Associated with Endocrine and Electrolyte Disorders;" *Dr. Gamber F. Tegtmeyer, Jr.*, "Management of Multiple Sclerosis;" and Doctor Morledge, "Recognition of Common Forms of Congenital Heart Disease in Adolescents and Adults."

Doctor Parsons was moderator of a panel on "Problems in the Use of Oral Contraceptives." Panel members were *Dr. Barbara A. Brew*, Doctor McLeod, Doctor Pois, and Doctor Tegtmeyer.

Dodge County Medical Assistants

The Dodge County Medical Assistants Society installed new officers during a meeting June 6 at the Court House in Beaver Dam. *Dr. George Drescher*, the Society's advisor, installed the officers: president, Mrs. Yvonne Straseski, Beaver Dam; president-elect, Mrs. Helen Allan, Waupun; recording secretary, Mrs. Kathy Conrad, Brownsville; and treasurer, Mrs. Jackie Steger, Juneau. Sylvia Neuman of Beaver Dam is the past president.

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OBITUARIES

Dr. Hyman S. Schumacher, 59, a Milwaukee physician for 35 years, died Mar. 17, 1967, in Hallandale, Fla.

Born in Milwaukee, Doctor Schumacher graduated from Marquette University School of Medicine in 1930 and completed his internship at Milwaukee General Hospital.

Doctor Schumacher was a member of the Wisconsin Academy of General Practice, The Medical Society of Milwaukee County, the State Medical Society of Wisconsin, and American Medical Association.

Surviving are his widow; a daughter, Mrs. Hugh Biller, Baltimore, Md., and a son, Gerald, Fox Point.

Dr. Adolph B. C. Bock, 64, a Sheboygan physician since 1933, died Mar. 23, 1967, in Sheboygan. Doctor Bock had retired in June 1965 for health reasons.

Born in Sheboygan, Doctor Bock received his BA degree from the University of Wisconsin and his Doctor of Medicine degree from the University of Pennsylvania. He completed his internship at Episcopal Hospital in Philadelphia and in 1931 he became resident physician at Mary J. Drexel Children's Hospital in Philadelphia before beginning his practice in Sheboygan in 1933.

Doctor Bock was an ardent golfer and he became the first amateur to win the Wisconsin State Open Championship in 1926. He was named to the Wisconsin State Golf Association's Hall of Fame in July 1965.

He was a member of the Sheboygan County Medical Society and served as its president in 1938. He was also a member of the State Medical Society of Wisconsin and American Medical Association.

Doctor Bock is survived by his widow, Helen.

Dr. Conrad T. Tasche, 94, who had practiced medicine in the Sheboygan area for 50 years, died Mar. 31, 1967.

Born in Sheboygan County, Doctor Tasche received his medical degree from the Detroit College of Medicine in 1897. He was one of the founders of the Sheboygan Clinic in 1922 and in 1931 started a practice with his son, Dr. Leslie W. Tasche, at the Medical Arts Building in Sheboygan. Upon his retirement in 1947, he was made an honorary member of the medical staff at Sheboygan Memorial Hospital and in 1948, was honored by the State Medical Society for his more than a half-century of devoted medical practice to the Sheboygan area.

Doctor Tasche was a member of the Sheboygan County Medical Society, the State Medical Society of Wisconsin, and American Medical Association.

Surviving are a son, Dr. Leslie W., and daughter, Mrs. Edgar Jung, both of Sheboygan.

Dr. Ralph J. M. Russell, 73, a Wauwatosa physician for 45 years, died April 24, 1967.

Doctor Russell attended Marquette University and was graduated from St. Louis University Medical School in St. Louis. He served in the navy in World War I. After his retirement several years ago, he served on the medical staff of county general hospital.

Doctor Russell was a part-time instructor at the Marquette University School of Medicine, a medical draft examiner in World War II, and a former member of the Wauwatosa safety commission. He was a member of The Medical Society of Milwaukee County, the State Medical Society of Wisconsin, and American Medical Association.

Doctor Russell is survived by two daughters, Mrs. James Fay, Pewaukee, and Mrs. Robert Gebhardt, Mequon.

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SOCIETY RECORDS

MEMBERSHIP REPORT AS OF JUNE 2, 1967

NEW MEMBERS

Apte, U. S., 3010 West Howard Ave., Milwaukee 53221
Brown, Edwin M., 1725 West Wisconsin Ave., Milwaukee 53233
Collins, Richard A., 8700 West Wisconsin Ave., Milwaukee 53226
Garber, Richard D., Osseo 54758
Gregorski, Robert F., 2964 South 29th St., Milwaukee 53215
Halgrimson, Kenneth W., 605 Walker Ave., Eau Claire 54701
Kijner, Herry H., 2500 West Lincoln Ave., Milwaukee 53215
Kreitzer, Frank V., 8700 West Wisconsin Ave., Milwaukee 53226
Najat, Hushang, 921—16th Ave., Monroe 53566
Nelson, John W., 8700 West Wisconsin Ave., Milwaukee 53226
Organick, Avrum B., 561 North 15th St., Milwaukee 53233
Santiago, Fernando S., 2709 Sixth St., Monroe 53566
Snider, Gordon L., V. A. Center, Wood 53193
Stewart, Richard D., 1725 West Wisconsin Ave., Milwaukee 53233
Tibbets, Palmer G., 7400 West Center St., Milwaukee 53210
Wiegmann, Otto A., 1700 West Wisconsin Ave., Milwaukee 53233

REINSTATED

Ansfield, David J., 208 East Wisconsin Ave., Milwaukee 53202
Whiteway, Robert E., 1836 South Ave., La Crosse 54601

CHANGES OF ADDRESS

Barta, R. F., Elm Grove, to 10125 West North Ave., Milwaukee 53226
Bolles, Carlton S., Green Bay, to 803 West St., Francis Rd., De Pere 54115
Brooks, Kenneth H., 5942 Sixth Ave., Kenosha 53140
Cafaro, Anthony F., Waukesha, to 5000 West Chambers St., Milwaukee 53210
Cron, Roland S., 324 East Wisconsin Ave., Milwaukee 53202
Erwin, Chesley P., 14850 Westover Road, Elm Grove 53122
Finn, Charles J., 811 East Wisconsin Ave., Milwaukee 53202
Gersch, George P., West Salem, to 1752 Tamarack N.W., Grand Rapids, Michigan 49504
Goldstein, Frank P., 524 Main St., Racine 53403
Grossman, Thomas W., 811 East Wisconsin Ave., Milwaukee 53202
Grumke, Erwin H., Madison, to 1842 Winchester Road North, St. Petersburg, Florida 33710
Hillery, Glenn C., 235 North Madison, Lancaster 53813
Joseph, Leo G., 630 South Tenth, La Crosse 54601
Kappus, Harold C., Chicago, Ill., to 1161 Sheridan Rd., Apt. 5, Kenosha 53140
Leach, John E., Burlington, to The Thompson Clinic, Moss Point, Mississippi 39563
Lewinnek, Walter, P. O. Box 394, Merrill 54452
Litofsky, Arthur, Milwaukee, to Headquarters 8669, Fort Lewis, Washington 98433
Matus, Simon, Smithtown, New York, to Box 222, Station H, Central Islip, New York 11722
McCabe, Lloyd B., Washington, D. C., to 8701 Sundale Drive, Silver Springs, Maryland 20910
Meyer, Jules O., 720 East Wisconsin Ave., Milwaukee 53202
Milson, Stuart E., APO San Francisco 96307, Calif., to USARV 93rd Evacuation Hospital, APO San Francisco 06491, Calif.
Moody, L. W., Bayfield, to Route 3, Park Rapids, Minn. 56470
Noonan, Patrick J., 811 East Wisconsin Ave., Milwaukee 53202
Ravn, Erling O., Jr., P. O. Box 376, Merrill 54452
Reynoso, Gustavo, Milwaukee, to 5900 South Lake Shore Drive, Cudahy 53110
Rosmann, Hermann K., Winnetka, Ill., to Route 1, Box 188a, Big Spider Lake, Hayward 54843
Rouman, William C., Milwaukee, to 13335 Gremoor Drive, Elm Grove 53122
Sauter, K. E., 5016 West Burleigh St., Milwaukee 53210
Schmidt, Claude W., 217 Wisconsin Ave., Waukesha 53186
Servis, Lionel T., 324 East Wisconsin Ave., Milwaukee 53202
Shumate, J. K., 1102 Waban Hill, Madison 53711
Slotnik, I. L., Milwaukee, to 4241 Red Road, Coral Gables, Florida 33155
Thoma, John W., 324 East Wisconsin Ave., Milwaukee 53202
Walsh, J. F., 100 West Monroe, Port Washington 53074

REMOVED FROM MEMBERSHIP

Bedford, Fred G., Milwaukee County, transferred to Oregon
Bolles, Carlton S., Brown County, resigned
Entwistle, Frederick R., Milwaukee County, transferred to South Dakota
Kline, Carl L., Marathon County, resigned
Laufenburg, Herb F., Shawano County, resigned
Pyka, Rudolf A., Wood County, transferred to California
Sablay, Nonito M., Walworth County, transferred to Ohio
Tibbitts, James A., Sauk County, transferred to Pennsylvania

DEATHS

Russell, Ralph J. M., Milwaukee County, Apr. 24, 1967
Knudson, Arthur H., Milwaukee County, May 17, 1967
Litzow, John A., Portage County, May 23, 1967
Schiek, Irving E., Onedia–Vilas County, May 27, 1967

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the wisconsin medical journal

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MEDICAL MEETINGS

POSTGRADUATE COURSES

1967 WISCONSIN

Sept. 8–9: Wisconsin Otolaryngological Society (with the Upper Michigan EENT Society), Bailey's Harbor.

Sept. 11–13: "The Teaching–Learning Process" conference for nurses, University Extension, Ellison Bay.

Sept. 11–15: Refresher courses for inactive nurses, University Extension, Madison.

Sept. 14: Adolf Gundersen Medical Foundation and Wisconsin Heart Association Symposium on Stroke, at Wisconsin State University at La Crosse.

Sept. 14: Scientific program, Luther Hospital Staff Day, Eau Claire. Inquiries to George E. Wahl, M.D., 616 Grand Ave.

Sept. 14–16: "Group Dynamics" conference, University Extension, Ellison Bay.

Sept. 15–16: Fall meeting, Wisconsin Surgical Society, Land O' Lakes.

Sept. 15–16: Annual meeting, Wisconsin Society of Internal Medicine, The Gateway Hotel and Inn, Land O' Lakes.

Sept. 15–17: Fall meeting, Wisconsin Radiological Society, Oshkosh.

Sept. 16–17: Annual fall meeting, Wisconsin Society of Anesthesiologists, The Pioneer, Oshkosh.

Sept. 21: Wisconsin Hospital Association, "Health Careers for Auxiliaries," Milwaukee.

Sept. 27–29: Annual meeting and scientific assembly, Wisconsin Academy of General Practice, Pfister Hotel, Milwaukee.

Sept. 29: University of Wisconsin "Pediatric Day," Madison.

Oct. 4–6: Annual meeting, Wisconsin Nurses Association, Milwaukee.

Oct. 9–20: Advanced Maternity Program in Delivery Room Nursing for graduate nurses, Marquette University College of Nursing, Milwaukee

Oct. 10–12: Annual meeting, Wisconsin Division of American Cancer Society, Oshkosh.

Oct. 13: Industrial Health Clinic, sponsored by the State Medical Society of Wisconsin, Employers Mutuals new building complex, Wausau.

Oct. 16–20: Wisconsin Work Week of Health, State Medical Society of Wisconsin, Madison.

Oct. 16–21: Postgraduate course, "Basic and Clinical Aspects of Therapy in Advanced Cancer," University of Wisconsin Medical Center, Madison.

Oct. 20: Annual meeting, Wisconsin Orthopedic Society, Wingspread, Racine.

Oct. 21: Annual fall cancer conference (The Cancer Scrimmage), University of Wisconsin Medical Center, Madison.

Nov. 2–3: Conferences in Geriatric and Psychiatric Nursing, University Extension, Madison.

Nov. 6–17: Advanced Maternity Program in Delivery Room Nursing for graduate nurses, Marquette University College of Nursing, Milwaukee.

Nov. 8–9: Wisconsin Welfare Council conference, Pfister Hotel, Milwaukee.

Nov. 9: Conference for Nursing Home Nurses, University Extension, Milwaukee.

Nov. 9–10: Milwaukee Medical Conference, sponsored by The Medical Society of Milwaukee County, County Hospital, Milwaukee.

Nov. 10: Conference for Nursing Home Nurses, University Extension, Wausau.

Nov. 10–12: Fall meeting, Wisconsin Society of Pathologists (jointly with Wisconsin Association of Medical Technologists), Milwaukee.

Nov. 13–14: Quackery conference, sponsored by State Medical Society of Wisconsin, Milwaukee Auditorium.

Nov. 16: State School Health Council, Wisconsin Center, Madison.

Nov. 17: Medical-Legal-Industrial Symposium on "Pulmonary Diseases in Industry," sponsored by Mount Sinai Hospital, at Pfister Hotel, Milwaukee.

Dec. 6: UW "In-Depth" postgraduate teaching program, Madison.

1968 WISCONSIN

Jan. 15–26: Advanced Maternity Program in Delivery Room Nursing for graduate nurses, Marquette University College of Nursing, Milwaukee.

Jan. 18: UW "In-Depth" postgraduate teaching program, Madison.

Feb. 7–8: "Modern Separation Methods of Macromolecules and Particles," University of Wisconsin, Madison.

Feb. 12–23: Advanced Maternity Program in Delivery Room Nursing for graduate nurses, Marquette University College of Nursing, Milwaukee.

Feb. 21: UW "In-Depth" postgraduate teaching program, Madison.

Mar. 4: Postgraduate course, "Hypoglycemias in Infants and Children," sponsored by Marquette University at Children's Hospital, Milwaukee.

Mar. 11: Postgraduate course, "Etiology and Management of Nephrosis in Children," sponsored by Marquette University at Children's Hospital, Milwaukee.

Mar. 11–22: Advanced Maternity Program in Delivery Room Nursing for graduate nurses, Marquette University College of Nursing, Milwaukee.

Mar. 18: Postgraduate course, "Prevention of Mental Retardation," sponsored by Marquette University at Children's Hospital, Milwaukee.

Mar. 21: UW "In-Depth" postgraduate teaching program, Madison.

Mar. 25: Postgraduate course, "Emotional Crises Among Adolescents," sponsored by Marquette University, Milwaukee.

Mar. 27–28: Sports Medicine and General Medicine, University of Wisconsin, Madison.

Apr. 4–5: Wisconsin Anti-Tuberculosis annual meeting, Milwaukee.

Apr. 4–6: Fetus and Newborn, University of Wisconsin, Madison.

Apr. 18–19: Conference for Directors of Nursing in Small Hospitals, University Extension, Marshfield.

Apr. 22–May 3: Advanced Maternity Program in Delivery Room Nursing for graduate nurses, Marquette University College of Nursing, Milwaukee.

May 9–10: Conference for Directors of Nursing in Small Hospitals, University Extension, Madison.

May 14–16: Annual meeting, State Medical Society of Wisconsin, Milwaukee.

June 8: Semi-annual meeting, Wisconsin Society of Pathologists, University Hospitals, Madison.

1967 NEIGHBORING STATES

Sept. 21–23: Annual meeting, American Association of Medical Clinics, Drake Hotel, Chicago, Ill.

Sept. 21–24: Annual meeting of American Medical Writers' Association, Palmer House, Chicago, Ill.

Oct. 2–6: Annual clinical congress, American College of Surgeons, Chicago.

Oct. 4–5: Annual Midwest Interprofessional Seminar on Diseases Common to Animals and Man, University of Missouri, Columbia.

Oct. 11: Third Annual Kidney Disease Symposium, Sheraton–Chicago Hotel, Chicago.

Oct. 12–13: Head and Neck Radiology Conference, Department of Radiology, College of Medicine of the University of Illinois, Chicago.

Oct. 14–20: Annual Otolaryngologic Assembly, at Illinois Eye and Ear Infirmary, Medical Center, Chicago.

1967 OTHERS

Sept. 29–Oct. 3: Annual meeting, American Society of Anesthesiologists, Las Vegas, Nev.

Oct. 21–26: Annual Meeting, American Academy of Pediatrics, Washington, D. C.

Oct. 23–27: American Public Health Association, Hotel Fontainebleau, Miami Beach, Fla.

November: Association of State and Territorial Health Officers, Washington, D. C.

Nov. 16–19: Annual convention, National Society for Crippled Children and Adults, Century Plaza Hotel, Los Angeles, Calif.

Nov. 26: Ninth national conference on the medical aspects of sports, in conjunction with the annual clinical convention of the American Medical Association, Nov. 26–29, Houston, Tex.

1968 OTHERS

Jan. 14–18: Second annual meeting of the Society of Cryo-Ophthalmology, Miami Beach, Fla.

May 4–9: Annual teaching seminar, International Academy of Proctology, Montreux–Palace Hotel, Montreux, Switzerland.

Oct. 21–25: Annual Clinical Congress, American College of Surgeons, Atlantic City, N.J.

For listing of other meetings see the JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION.

Symposium on Stroke, La Crosse

The Adolf Gundersen Medical Foundation, with the cooperation of the Wisconsin Heart Association and the La Crosse County Heart Unit, will present a Symposium on Stroke at Valhalla Hall, The Wisconsin State University at La Crosse, Thursday, September 14. The program chairman, Dr. A. Erik Gundersen, extends an invitation to all interested physicians to attend. Registration fee of $5 may be sent to Doctor Gundersen, Department of Thoracic Surgery, Gundersen Clinic, Ltd., La Crosse, Wis. 54601.

Guest speakers will be Dr. John Marshall, neurologist to the West Middlesex Hospital, Middlesex, ENGLAND; Dr. John S. Meyer, professor and chairman, Department of Neurology, Wayne State University School of Medicine, Detroit, Mich.; Dr. Irving S. Wright, clinical professor of medicine, Cornell University Medical College, and president, American College of Physicians; Dr. Michael E. De Bakey, professor and chairman, Department of Surgery, Baylor University College of Medicine, Houston, Tex.; and Dr. Michael M. Dacso, professor of rehabilitation medicine, New York University School of Medicine, and president, American Academy of Physical Medicine and Rehabilitation.

Topics include: "The Significance and Management of Transient Ischemic Attacks," "Anticoagulant Therapy in the Treatment of Cerebrovascular Disease," "Concepts Underlying the Surgical Management of Cerebrovascular Insufficiency," "Prevention of Secondary Deterioration in the Hemiplegic Patient," and an informal panel discussion with questions and answers and audience participation on the subject: "Current Concepts in Stroke Patient Management." Moderator of the panel will be Dr. C. Norman Shealy of the Department of Neurosurgery, Gundersen Clinic, Ltd.

Wisconsin Society of Internal Medicine

The annual meeting and scientific program of the Wisconsin Society of Internal Medicine will be held at the Gateway Hotel and Inn, Land O' Lakes, September 15 and 16. The two-day event, which promises to be the largest ever held, is being supported by a number of drug firms and by the American College of Physicians and the Wisconsin Heart Association.

Dr. Richard V. Ebert, chairman of the Department of Medicine at the University of Minnesota, will present the annual Middleton lecture on "Coronary Prevention and Rehabilitation." Doctor Ebert will speak at 2:30 PM Friday, September 15.

The Society's annual business meeting and election of officers will take place at 12:30 PM Friday. *Dr. Edward K. Ryder, Jr.* of Madison will be installed as president of the Society, succeeding *Dr. John H. Wishart* of Eau Claire.

At the annual meeting banquet Friday evening there will be an interesting program on "Four Days of Gemini '4'." Guest of honor at the banquet will be Dr. Rudolph Kampmeier, president-elect of the American College of Physicians.

In addition to the usual recreational activities, there will be the first annual WSIM golf tournament for members and wives preceding the meeting, on Thursday, September 14. *Dr.* and Mrs. *Robert F. Madden* of Milwaukee are co-chairmen.

A tentative program has been arranged as follows:

FRIDAY, SEPTEMBER 15

CORONARY SHOCK AND NEWER DRUGS, by Dr. John T. Kimball, Jr., New York City.

Panel Discussion—CORONARY CARE UNIT, Drs. John T. Kimball, Jr.; *George E. Owen*, Eau Claire; F. Mason Sones, Jr., Cleveland, O., and *Lawrence Wolf*, Milwaukee (panelists).

CORONARY ARTERIOGRAPHY, Dr. F. Mason Sones, Jr., Cleveland, O.

PRESENT STATUS OF CORONARY AND HEART SURGERY, Dr. C. Walton Lillehei, Minneapolis, Minn.

Panel Discussion—SELECTION OF PATIENTS FOR CORONARY SURGERY, *Dr. John H. Huston*, Milwaukee (moderator), Drs. C. Walton Lillehei and F. Mason Sones, Jr., and John Sauter (panelists).

CORONARY PREVENTION AND REHABILITATION, Dr. Richard V. Ebert, chairman, Department of Medicine, University of Minnesota (Annual William S. Middleton Lecture).

SOCIO-ECONOMIC—MEDICARE–MEDICAID, *Dr. Addis C. Costello*, Milwaukee (moderator), Dr. Robert S. Long of Omaha, Nebr., president-elect of ASIM, and Donald McIntyre, director of medicare claims of Wisconsin Physicians Service, Madison (panelists).

SATURDAY, SEPTEMBER 16

EXTRACRANIAL VASCULAR DISEASE, DIAGNOSIS AND TREATMENT, *Dr. Robert M. Green*, Gundersen Clinic, La Crosse.

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MEDICAL MEETINGS *continued*

EXPERIENCES WITH DEVELOPMENT AND USE OF A CORONARY CARE UNIT IN A COMMUNITY HOSPITAL, *Dr. George E. Owen*, Midelfart Clinic, Eau Claire.

ASSESSMENT OF LEFT VENTRICULAR FUNCTION IN ATRIAL FIBRILLATION, *Dr. Ramon Lange*, Department of Medicine, Marquette University School of Medicine, Milwaukee.

NEWER DEVELOPMENTS IN ELECTROCARDIOGRAPHY, Dr. Richard Wasserburger, University of Wisconsin and Veterans Administration Hospital, Madison.

CELIAC ARTERIOGRAPHY, EXPERIENCES AT THE MARSHFIELD CLINIC, *Dr. Deiter Voss*, Marshfield Clinic, Marshfield.

CATECHOL AMINE DEPLETION, PATIENTS TREATED WITH RESERPINE FOR HYPERTENSION, Professor Bartocelli, Department of Medicine, Marquette University School of Medicine, Milwaukee.

HOMOGRAFT BOWEL TRANSPLANTS, EXPERIENCE AT THE UNIVERSITY OF WISCONSIN HOSPITALS, *Dr. George Rowe*, Department of Medicine, UW Medical School, Madison.

CHELATION TREATMENT OF WEGNER'S GRANULOMATOSIS, Drs. P. L. Hansotia and *H. A. Peters*, Department of Neurology, UW Medical School, Madison.

Other speakers: Dr. Edward C. Rosenow, Jr. of Philadelphia, Pa., executive director of ACP, and Dr. R. H. Kampmeier, president-elect of ACP.

Course in Laryngology and Bronchoesophagology

The Department of Otolaryngology of the Illinois Eye and Ear Infirmary and the College of Medicine of the University of Illinois at the Medical Center, Chicago, will conduct a postgraduate course in laryngology and bronchoesophagology from November 6 through 17. This course is limited to 15 physicians and will be under the direction of Paul H. Holinger, M. D. Instruction will be provided by means of animal demonstrations and practice in bronchoscopy and esophagoscopy, diagnostic and surgical clinics, as well as didactic lectures.

Interested registrants will please write directly to the Department of Otolaryngology, College of Medicine of the University of Illinois at the Medical Center, P. O. Box 6998, Chicago, Ill. 60680.

Congress on Occupational Health

A multiplicity of occupational health problems will be examined during the 27th Annual Congress on Occupational Health in Atlanta, Ga., September 25–26. Sponsored by the American Medical Association's Council on Occupational Health, the two-day Congress will be held at the Regency Hyatt House.

Following an opening address by Milford O. Rouse, M. D., AMA president, the conferees will begin their examination of health problems in eight key areas. These include: small plant problems, occupational health programs for government employees, responsibility of the physician in off-the-job accident preven-

tion, screening in occupational medicine, occupational health in agriculture, epidemiology of occupational medicine, cooperation between medical societies and workmen's compensation administrators, and psychologic problems in occupational medicine including a discussion of alcoholism in industry.

A Congress highlight will be the presentation of the Annual Physician's Award of the President's Committee on Employment of the Handicapped during pre-luncheon ceremonies September 25.

The American Academy of General Practice has accepted the program for 11 elective hours of credit. Additional information may be obtained by writing: Council on Occupational Health, American Medical Association, 535 North Dearborn St., Chicago, Ill. 60610.

Symposium on Acute Leukemia

A Symposium on Acute Leukemia and Burkitt's Tumor will be held at the Boston Museum of Science in Boston, Mass., September 20. This symposium is being sponsored by the American Cancer Society and the National Cancer Institute. The meeting is open to all members of the medical profession and students. There is no advance registration or fee.

For further information, write: Dr. Jack W. Milder, Research Department, American Cancer Society, Inc., 219 East 42 Street, New York, N. Y. 10017.

Hematology Program of ACP

The American College of Physicians is presenting a program on Hematology: Current Concepts and Developments, September 18–21 at the University of California Center for Health Sciences, Los Angeles.

Fees: ACP members, $60; nonmembers, $100. Send all registrations, requests for information, and applications to: Edward C. Rosenow, Jr., M. D., Executive Director, ACP, 4200 Pine Street, Philadelphia, Pa. 19104.

Industrial Health Clinic

The State Medical Society of Wisconsin has planned an all-day program on Industrial Health at the new building complex of Employers Mutuals Insurance Co. at Wausau on October 13. The clinic will attract small plant managers, safety directors, personnel directors, nurses, and physicians who will discuss the feasibility and problems associated with the establishment of part-time health programs in small industries. The day's activities include a plant tour and review of Employers Mutuals.

Tentatively a second spring industrial health clinic is being planned for late March or early April of 1968.

AAGP Scientific Assembly in Dallas

A frank exploration of the doctor–patient relationship is one of the highlights awaiting family doctors attending the 19th Annual Scientific Assembly of the American Academy of General Practice, September 18–21 in Dallas, Tex.

The four-day program will feature 26 top speakers on such topics as estrogenic "cycling" of the

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after-40 woman, the young cardiac, maternal substitutes for the "unmothered" child of the working mother, medicine in the Mekong Delta, and sexual aberrations. The scientific program will follow the annual meeting of the Academy's policy-making Congress of Delegates September 16–18 at the Statler–Hilton hotel in Dallas.

The scientific program also will include the popular "bedside" clinical refresher courses, initiated two years ago at the San Francisco Assembly. The courses this year will be conducted by the faculty of Southwestern Medical College.

Assembly-goers also will have an opportunity to take advantage of the success of last year's pilot test of programmed learning machines. Approximately 100 machines containing specially-programmed courses from one to several hours in length will be available in enclosed cubicles adjacent to the exhibit area.

Attendance at the four-day Assembly lecture program offers 14 hours of approved postgraduate credit to Academy members. Academy doctors can accrue a total of 19 or more hours of postgraduate study credit at the Assembly by attending all lectures and the special courses.

Medical–Legal–Industrial Symposium, Milwaukee

Mount Sinai Hospital, Milwaukee, is presenting its sixth annual Medical–Legal–Industrial Symposium on "Pulmonary Diseases in Industry" Friday, November 17, at the Pfister Hotel in Milwaukee. The program will begin at 8:45 AM and terminate at 4:00 PM.

The following speakers will present papers:

Nathan Grossman, M.D., *Respiratory System—Its Structure in Health and Disease;* Ross Kory, M.D., *Pulmonary Function—Normal or Abnormal?;* Kiesl K. Kaufman, M.D., *Pneumoconiosis;* Helen Dickie, M.D., *Organic Dusts and Noxious Fumes;* Benjamin Narodick, M.D., *Chest Trauma;*

Donald P. Schlueter, M.D., *Tuberculosis in Industry;* Joseph Fagan, L.L.B., *Incidence of Pulmonary Disease in Wisconsin;* Gordon Snider, M.D., *Evaluation of Disability Impairment in Pulmonary Disease;* David Cugell, M.D., *Chronic Obstructive Pulmonary Disease;*

O. A. Sander, M.D., *Prevention of Lung Disease in Industry;* Lawrence Gillick, Attorney, *The Problems from the Standpoint of the Claimant;* and Edward T. O'Neill, Attorney, *The Problems from the Standpoint of the Respondent.*

Further information from: Raymond L. Rice, M.D., Chairman, 1967 Symposium Committee, Mount Sinai Hospital, 948 North 12th Street, Milwaukee 53233.

Inter-American Congress of Cardiology

The Eighth Inter-American Congress of Cardiology has been scheduled to be held in Lima, Peru,

Remember for November!

"THE HIGH COST OF QUACKERY in Lives and Money"

MONDAY & TUESDAY, NOVEMBER 13 & 14
Milwaukee Auditorium

This free public meeting will feature nationally prominent authorities in health, law, government, and economics. The program is sponsored by the State Medical Society of Wisconsin with The Medical Society of Milwaukee County, and with the support of the American Medical Association, and the U.S. Food and Drug Administration.

Circle the dates—November 13-14, Milwaukee Auditorium

from April 23–27, 1968, under cosponsorship of the Inter-American and Peruvian Societies of Cardiology.

The tentative program calls for five morning plenary programs and 12 panels or symposia to be held during afternoon meetings. Expectations are that 240 individual papers will be presented daily at six simultaneous sessions.

Further information concerning the Congress may be obtained from Dr. Dante Penaloza, Pablo Bermudez 274, Lima, Peru.

Hawaii Scientific Sessions

Three days of scientific sessions on "Problems in Cardiology," cosponsored by the Hawaii and American Heart Associations, have been scheduled from October 26–28 in Honolulu's Ilikai Hotel. The sessions follow the American Heart Association's Annual Meeting and Scientific Sessions to be held in San Francisco's Civic Auditorium from October 20–24.

Highlights of the Hawaii program will be symposia on "Cerebrovascular Disease: Recognition and Treatment," on "Coronary Artery Disease: Recognition and Treatment," and on "Surgical Treatment of Valvular Disease." In addition, panel discussions and papers on a variety of cardiovascular topics are scheduled.

Two travel tours to accommodate those who attend the Heart Association's meeting in San Francisco have been arranged.

The initial tour leaves San Francisco on October 23, returning on October 29. It includes a stopover on the Island of Hawaii with visits to the city of Hilo and its orchid farms and the Volcano National Park. The stay in Honolulu includes visits to the Polynesian Center and the historic Captain Cook and Pearl Harbor cruises.

A second flight, arranged especially for physicians and scientists who remain through the AHA's Annual Meeting program which ends October 24, leaves San Francisco on October 25 and returns October 29. This also embraces tours of the Polynesian Center, Pearl Harbor and other scenic launch cruises.

Further information concerning the scientific sessions program may be obtained from the Director of Medical Education, American Heart Association, 44 E. 23rd St., New York, N. Y. 10010.

Course on Congenital Heart Problems

A "Three Days of Cardiology" postgraduate course on Congenital Heart Disease Problems will be held on September 18–20 in the Jimmy Fund Auditorium of The Children's Hospital, Boston, Mass.

The course is cosponsored by the American Heart Association's Council on Clinical Cardiology and The Children's Hospital in cooperation with the Massachusetts Heart Association, and the Council on Rheumatic Fever and Congenital Heart Disease.

Registration fees are $60 for Members and Fellows of the two AHA Councils and $95 for nonmembers, including luncheons. Registration forms and

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additional information may be obtained from the Director of Medical Education, American Heart Association, 44 East 23rd Street, New York, N. Y. 10010.

Heart Association's Scientific Sessions

Six sessions on Clinical Cardiology of special interest to practicing physicians and simultaneous programs on various aspects of cardiovascular research have been scheduled for the American Heart Association's 40th annual Scientific Sessions. The three-day meeting will be held from October 20–22 in San Francisco's Civic Auditorium.

Highlighting the Clinical Cardiology program will be papers on clinical investigations, lectures, panels and symposia. Featured will be the first delivery of the Association's International Lecture, established on the occasion of Dr. Paul Dudley White's 80th birthday last year. The initial presentation, honoring the eminent Boston cardiologist for his world leadership in advancing cardiology, will be made by Gunnar Biorck of Stockholm's Karolinska Institute on the subject, "Biology of Myocardial Infarction."

Forms to register for the meeting, which include hotel reservation requests, and further information may be obtained through local Heart Associations or the AHA National Office, 44 East 23rd Street, New York, N. Y. 10010.

KIDNEY FOUNDATION OF ILLINOIS

presents its

3RD ANNUAL SYMPOSIUM ON CLINICAL ADVANCES IN KIDNEY DISEASES

Sheraton–Chicago Hotel

WEDNESDAY, OCTOBER 11, 1967

Guest speakers will include:

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Cleveland Clinic

Dr. Charles Kleeman
Cedars–Sinai Medical Center, Los Angeles

Dr. Robert L. Vernier
University of California at Los Angeles

Dr. Lowell King
Children's Memorial Hospital, Chicago

Dr. Willem J. Kolff
University of Utah Medical School

Topics will include:

Clinical Pharmacology of Diuretics, Approach to the Patient with Kidney Stones, Congenital Disorders of the Genitourinary Tract, Chronic Dialysis and Renal Transplantation, Evaluation of the Patient with Hypertension, Drug Therapy of Renal Diseases, and Conservative Management of Chronic Renal Failure.

REGISTRATION FEE: $15.00, including luncheon. $6.00 for students, interns, residents. Send registrations to Kidney Foundation of Illinois, 127 N. Dearborn St., Chicago, Ill. 60602.

American College of Physicians

The ACP has announced its 1967–1968 postgraduate courses as follows:

Sept. 18–21: Hematology: Current Concepts and Developments, Los Angeles, Calif.

Oct. 2–6: Clinical Cardiology, Loma Linda, Calif.

Oct. 9–13: Renal Diseases and Fluid and Electrolyte Balance, Seattle, Wash.

Nov. 15–18: Neurologic Aspects of Internal Medicine, Durham, N. C.

Nov. 27–30: Medical Genetics, Ann Arbor, Mich.

Dec. 4–8: Radio-isotopes and Nuclear Radiations in Medicine, Berkeley, Calif.

Dec. 11–15: Advances in Medical Oncology, Houston, Tex.

Jan. 15–19: Neurology and the Internist, Miami, Beach, Fla.

Feb. 5–9: Psychiatry and the Internist, Los Angeles, Calif.

Feb. 19–23: Intensive Care Units, Cincinnati, Ohio.

Feb. 28–Mar. 2: Hypertensive Cardiovascular Diseases: Mechanisms and Treatment, Montreal, P. Q., Can.

Mar. 14–16: The Clinical Selection of Patients for Cardiac Surgery, Rochester, Minn.

Mar. 18–22: Psychiatry and the Internist, Albany, N. Y.

Mar. 27–30: Current Concepts in Physiology of Respiration, Circulation and Electrolyte Metabolism, Boston, Mass.

Apr. 22–26: Clinical Endocrinology—Recent Advances in Diagnosis and Treatment, Rochester, Minn.

May 12–15: Frontiers in Gastroenterology, Philadelphia, Pa.

May 20–24: The Prevention and Early Detection of Disease in Clinical Practice, Philadelphia, Pa.

May 27–31: Auscultation of the Heart, Philadelphia, Pa.

June 10–14: Basic Principles in Internal Medicine —1968, Iowa City, Iowa.

June 17–19: Intensive Care Units, Denver, Colo.

June 19–21: Infectious Diseases—Mechanisms and Manifestations, Baltimore, Md.

National Inhalation Therapy Meeting

The American Association for Inhalation Therapy will hold its 13th Annual Meeting and Lecture Series at the Statler Hilton, Los Angeles, Calif., November 12–17. The meeting's theme will be "Exploring Unusual Atmospheres".

The A.A.I.T. was established in 1953 with a membership of 177. Today it has nearly 3,000 members and 37 chapters functioning throughout the United States.

Nonmembers interested in attending the meeting should request registration information from the Exexutive Secretary, A.A.I.T., 332 South Michigan Avenue, Room 904, Chicago, Ill. 60604.

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Composition: Each Mylanta chewable tablet or teaspoonful (5 ml.) of liquid contains: magnesium hydroxide, 200 mg.; aluminum hydroxide, dried gel, 200 mg.; simethicone, 20 mg. **Dosage:** one or two tablets, well chewed or allowed to dissolve in the mouth, or one or two teaspoonfuls of liquid to be taken between meals and at bedtime.

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FIFTH ANNUAL

Wisconsin Work Week of Health

SPONSORED BY THE STATE MEDICAL SOCIETY OF WISCONSIN

October 16–20, 1967

All sessions will be held in the State Medical Society Headquarters in Madison. This year over 30 firms, organizations, and agencies join the State Medical Society in cosponsoring this important event. All sessions are open to the general public. Encourage the interested people in your community to attend . . . and plan to attend yourself!

PROGRAM

MONDAY, OCTOBER 16: Medical Aspects of Traffic Safety and Rescue

THE ROLE OF MEDICAL CONDITIONS IN ACCIDENT CAUSATION: *James L. Karns*, Director, State Motor Vehicle Dept.

DETECTION OF THE MEDICALLY IMPAIRED DRIVER: *James L. Weygandt, M. D.*, Chairman, SMS Division on Safe Transportation

AUTOMOBILE DESIGN FOR SAFETY—LIP SERVICE OR REALITY?: (to be announced)

RESCUE OF ACCIDENT VICTIMS IN RURAL AREAS: *Joseph D. Farrington, M. D.*, Minocqua

RESCUE OF ACCIDENT VICTIMS IN METROPOLITAN AREAS: *Mr. Ed Rostkowski*, Department of Public Works, Milwaukee

COMMUNICATIONS IN RESCUE EFFORTS: *Capt. John M. Waters, Jr.*, U. S. Coast Guard, Washington, D. C.

TUESDAY, OCTOBER 17: Special Medical and Operational Problems in Nursing Home Administration

BIRD'S-EYE VIEW OF NURSING HOMES AND HOMES FOR THE AGED IN WISCONSIN: *Mr. Dale Jennerjohn*, State Board of Health

THE JOINT COMMISSION APPROVES EXTENDED CARE FACILITIES: *John D. Porterfield, III, M. D.*, Director, Joint Commission, Chicago

CHANGING MEDICARE STANDARDS FOR PARTICIPATION BY EXTENDED CARE FACILITIES: *Milton Bankoff, M. D.*, Dept. Chief, Nursing Home Branch, Division of Medical Care Administration, USPHS, Washington, D. C.

MEDICAL AND NURSING SPECIALIZATION IN THE EXTENDED CARE FACILITY: (to be announced)

WHAT THE EXTENDED CARE FACILITY EXPECTS FROM THE PHYSICIAN AND THE NURSE: *Rev. C. A. Becker*, President, American College of Nursing Home Administrators, Racine

HEALTH INSURANCE BENEFITS FOR EXTENDED CARE: *Mr. Louis Orsini*, Director, Health Insurance Council, New York

WEDNESDAY, OCTOBER 18: Scientific, Philosophical, and Ethical Considerations in Life Extension

WHO SHALL LIVE—WHO SHALL DIE?: *J. Ernest Breed, M. D.*, Chicago

SHOULD THE PATIENT'S WISHES BE CONSIDERED?: *John A. Spitell, M. D.*, Mayo Clinic, Rochester

WHAT IS LEGAL?: *Edwin J. Holman*, Department of Medical Ethics, AMA

CASE PRESENTATION: *W. W. Stead, M. D.*, Professor of Medicine, Marquette U. School of Medicine

REACTOR PANEL: *John B. Toussaint, M. D., Mr. John A. Kluwin*, (clergyman to be announced)

THURSDAY, OCTOBER 19: The Role of the Nurse

TRENDS IN NURSING TRAINING: (to be announced)

THE SPECTRUM OF PATIENT CARE VIEWED BY THE NURSE: *Eleanor C. Lambertsen, Ed. D., R. N.*, Director, Division of Nursing Education, Columbia U. Teachers College, New York

PHYSICIAN–NURSE RELATIONSHIPS: *Hans O. Mauksch, Ph. D.*, Dean, Liberal Arts, IIT, Chicago

REACTOR PANEL: *L. I. Stein, M. D.*, Mendota State Hospital; *John Rankin, M. D.*, UW Medical School; *Rose Marie Chioni, R. N.*, UW School of Nursing; *Mrs. Carol Lindeman, R. N.*, Eau Claire State U. School of Nursing

LIABILITY OF THE MD AND NURSE IN PATIENT CARE: *Nathan Hershey*, Assistant Director of Health Law, University of Pittsburgh

Following adjournment, a meeting will be called of the Commission on Hospital Relations and Medical Education

FRIDAY, OCTOBER 20: Community Resources in Rehabilitation of the Mentally Ill and Retarded

PANEL ON FIRST FRIENDS, HALFWAY HOUSES, DAY PROGRAMS, AND COMMUNITY MENTAL HEALTH CENTERS: *Rev. Richard Larson*, Madison; *Mr. Walter Conner*, Eau Claire; *Mr. Robert Hall*, Madison; *Mr. C. A. Cahill*, Racine

REACTOR PANEL: *D. A. Treffert, M. D.*, Superintendent, Winnebago State Hospital; *R. L. Lenz*, Mental Health Consultant, State Dept. of Public Welfare; *E. H. Jochimsen, M. D.*, Sheboygan

ROLE OF WORK IN THE REHABILITATION OF THE MENTALLY HANDICAPPED: *Adrian E. Towne*, Director, Vocational Rehabilitation Division, State Board of Vocational, Technical, and Adult Education

J. L. Karns

H. O. Mauksch, PhD

Rev. Richard Larson

Nathan Hershey

Walter Conner

E. C. Lambertsen, EdD

J. E. Breed, MD

W. W. Stead, MD

COMPREHENSIVE COMMUNITY MENTAL HEALTH CENTERS IN WISCONSIN: *Kenneth H. Rusch, M. D.*, Community Services Director, State Department of Public Welfare

SUMMATION AND DISCUSSION: *Milton H. Miller, M. D.*, Dept. of Psychiatry, UW Medical School

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It is your opportunity to give financial assistance to the charitable, educational and scientific aspects of medicine as they relate to the health and well-being of the people of Wisconsin. Gifts may take a number of forms such as cash, life insurance, securities, land, books, instruments, stamp and coin collections, works of art and other artifacts. Some physicians are making the Foundation a beneficiary of their wills. In any event, all contributions to the Foundation are deductible for income tax purposes. Checks may be made out to: CES Foundation, and sent to CES Foundation, State Medical Society of Wisconsin, Box 1109, Madison, Wisconsin 53701.

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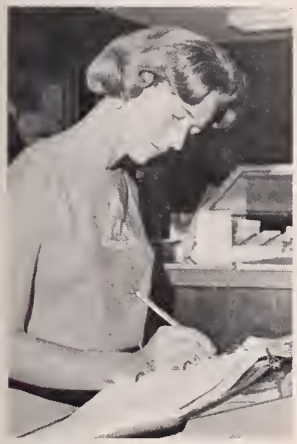
100,000 Visitor Signs in at Museum

The 100,000th visitor to the Museum of Medical Progress and Stovall Hall of Health in Prairie du Chien signed the guest register July 11. The special visitor was Mrs. Jed Senger of Richardson, Tex.

Mrs. Senger, her husband, and two boys enjoyed a full day of adventure as guests of the Museum. They were given a free tour of the Museum, were treated to a cruise on the Mississippi River, and were luncheon guests at a Prairie du Chien restaurant. Gordon Peckham, curator, also presented the entire family with gifts from the Museum.

Jed Senger was originally a Wisconsin boy. He was born and raised in Beloit. He moved to Texas and married. This summer he wanted to show his family Wisconsin. And this occasion certainly must have added a few extra moments of pride in his home state.



Mrs. Jed Senger of Richardson, Tex., signs the guest register as the 100,000th visitor of the Museum of Medical Progress at Prairie du Chien. The Museum has been open since 1961.

Photos courtesy
PRAIRIE DU CHIEN
COURIER-PRESS

Governor Knowles Extends Helping Hand to Museum

In July, Governor Warren P. Knowles sent a letter to Wisconsin pharmacists asking their assistance in calling attention to one of the state's historic sites—the Museum of Medical Progress and Stovall Hall of Health in Prairie du Chien.

The appeal was part of a larger program to stimulate industrial and business growth at several levels in Wisconsin, this one being the tourist industry. The pharmacists were chosen particularly because the "Museum contains an excellent pharmacy display and having people visit the museum leads to a greater appreciation of your profession."

Governor Knowles indicated that he could supply a quantity of brochures about the Museum for distribution to the pharmacists' regular patrons as they shopped, and to out-of-town visitors. The brochures are provided free of charge by the CES Foundation of the State Medical Society.

Professionals in other fields have also been sent letters by the Governor to promote travel to other historic sites in which they have a special interest.

State Medical Society Seeks Study of Chiropractic

The State Medical Society is sponsoring a legislative resolution asking for a detailed study of chiropractic. The study would consider chiropractic's basis and methods of treatment as a guide to formulation of state policy for its regulation.

The proposal was introduced in the state assembly under the names of three assemblymen, acting at the request of the Society, following a recommendation of its House of Delegates which met in annual session in May.

It asked for a study by the Joint Legislative Council, consisting of 15 leaders representing both legislative houses and both political parties, and suggested that the study "include an investigation into the basis and efficacy of chiropractic treatment and any limitations to be placed upon the practice of chiropractic in Wisconsin, and to develop such information as will enable the legislature to deal more effectively and with greater understanding with this subject for the protection of the health of the citizens of this state."

MEETINGS AND SPECIAL EVENTS HELD AT THE STATE MEDICAL SOCIETY "HOME" DURING THE MONTH OF JULY 1967

11	Board of Trustees, Dane County Medical Society, and New Member Dinner
14	Commission on Scientific Medicine
20	Commission on Hospital Relations and Medical Education
20	Licensing examination for professional nurses, State Department of Nurses
21	Licensing examination for professional nurses, State Department of Nurses
27	Ad Hoc Committee on Alcoholism, State Vocational Rehabilitation Division
28	Executive Committee, Council
29	Executive Committee, CES Foundation
29	Board of Trustees, CES Foundation
29	Council
29	Cancer Study Committee
29	Wisconsin Regional Medical Program, Inc.

Meetings not held in the Society "Home" but have a direct relationship are printed in italics, with the location in parentheses.

STATE MEDICAL SOCIETY OF WISCONSIN

created by an Act of the Territorial Legislature of 1841

Madison, Wisconsin, U.S.A.

WHEREAS, On July 19, 1967 Milton D. Davis, M.D., was taken from among us by an untimely death; and

WHEREAS, Words alone are inadequate to express the manner in which Doctor Davis served his profession, his fellow man, his family, his community and all organizations which were fortunate enough to have benefited from his strong, generous and unstinting leadership; and

WHEREAS, He demonstrated his willingness to give of himself by service as President of the Milton College Board of Trustees, the Milton College Alumni Association, the Milton Historical Society, the Milton Seventh Day Baptist Church, the Rock County Medical Society, Mercy Hospital Medical Staff, Edgerton Memorial Community Hospital Staff and as a member of the Council, the Planning Committee of the Council and the Commission on Medical Care Plans of the State Medical Society; and

WHEREAS, His wife and family encouraged and helped him in his unlimited endeavors for the health and welfare of all people; now therefore be it

RESOLVED, That this Council place on record its deep appreciation for having reaped the benefit of his wisdom and for having known him as a friend; and be it further

RESOLVED, That our heartfelt sympathy be extended to Mrs. Davis and Milton D. Davis, Jr., for the great loss we share; and be it finally

RESOLVED, That a copy of this resolution be printed in the Wisconsin Medical Journal as an expresson of sympathy from the entire medical profession of Wisconsin who subscribe to the fact that the world is a better place for Dr. Milton Davis having lived in it.

James C. Fox, M.D.
CHAIRMAN OF THE COUNCIL

H. J. Kief M.D.
PRESIDENT

Attest: C. H. Crownhart
SECRETARY

"Medical Memo" Historical Series Provided Weekly Newspapers

"Medical Memo," a cartoon panel series depicting important historic events, personal vignettes, and health facts of interest to the people of Wisconsin, is now being provided to all weekly newspapers in the state.

Written by SMS staff, with illustrations by Madison artist, Jim Johnston, "Medical Memo" will glean many of its facts from displays in the Museum of Medical Progress, Prairie du Chien, and will identify the Museum as the source.

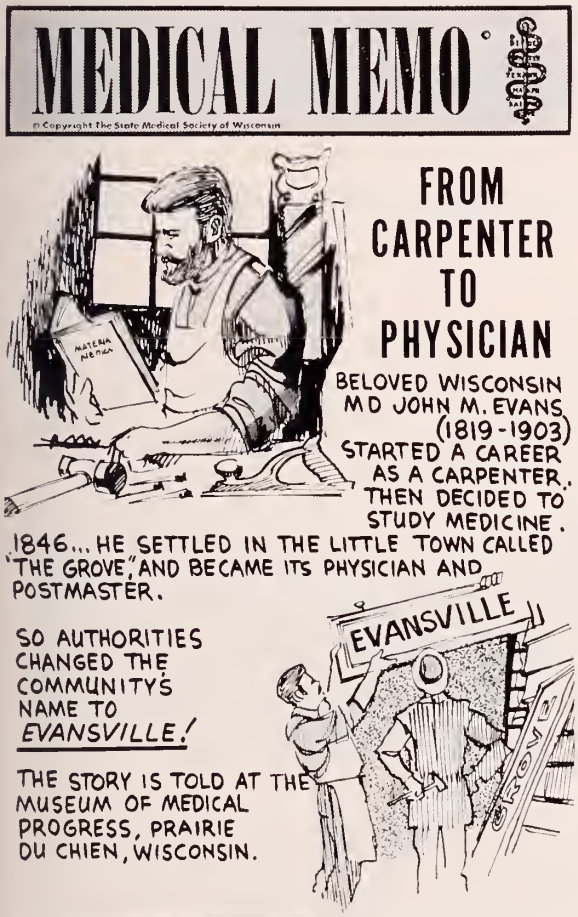
Wisconsin history sources and SMS records will also provide items of drama, humor, or unusual interest.

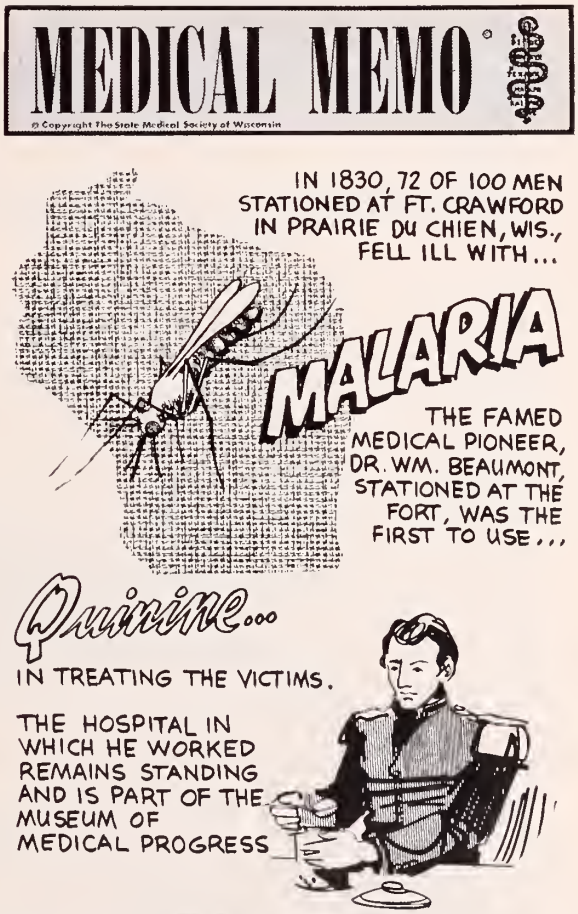
The first panel to appear, the week of July 17th, explained the Aesculapian staff. Other subjects in the first weeks will mention colorful old folk remedies, an item about the malaria epidemic at Ft. Crawford (now the Museum of Medical Progress) in 1830; life-expectancy figures in Wisconsin in 1850 and the present; and items in the lives of late Wisconsin MDs Bertha Reynolds, John M. Evans, and F. X. and George Pomainville.

The 235 weekly papers in the state are provided the service at no charge as mats or reproduction proofs, to meet their mechanical requirements.

* * *

Physicians are encouraged to promote their use and to extend words of appreciation to their local newspapers when they are printed.





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NEWS OF WISCONSIN PHYSICIANS

Dr. Giesen Elected to AAGP Group

Dr. Conrad Giesen, Superior, has been elected to active membership in the American Academy of General Practice.

Dr. Gottlieb Elected to Office

Dr. A. M. Gottlieb, Madison, was elected vice-president and member of the executive committee of the American Physicians Art Association. Doctor Gottlieb has won several prizes for his paintings. He is a professor of medicine at the University of Wisconsin and director of the Veterans Administration Hospital.

Dr. Hein Joins Monroe Clinic

Dr. William E. Hein, Brodhead, recently joined The Monroe Clinic. He has been in Brodhead since 1955. Doctor Hein graduated from the University of Wisconsin Medical School in 1954 and served his internship at St. Mary's Hospital in Duluth, Minn.

Dr. Ozturk Joins Neillsville Clinic

Dr. Cahit H. Ozturk, New York City, has joined the Neillsville Clinic as physician and surgeon and an associate of *Dr. Kenneth Manz* and *Dr. Bahri Gungor*. Doctor Ozturk was graduated from the Medical School, University of Istanbul, in 1943. After graduation he served three years in the Turkish Army as a lieutenant. At the completion of his Army service, he practiced in Mardin for seven years. In 1953 he entered the University of Nebraska where he was an intern, and served two years in surgical training in Atlanta, Ga. Doctor Ozturk has been practicing general surgery in New York since 1956.

Dr. Hirschboeck Heads Heart Fund Drive

Dr. John S. Hirschboeck, Milwaukee, coordinator of the Wisconsin Regional Medical Program, Inc., recently was named state campaign chairman of the 1968 Wisconsin Heart Fund drive. The drive is to begin in February 1968.

Dr. Custer Attends Conference

Dr. G. Stanley Custer, Jr., Marshfield, recently attended the National Conference on Medical Costs which was held in Washington, D. C. The purpose of the conference was to discuss how the costs of medical service can be lowered without impairing the quality. Doctor Custer served on the panel concerned with hospital costs.

Wisconsin Physicians on AMA Program

Dr. Francis M. Forster, neurologist in the Wisconsin Epilepsy Center; *Dr. James E. Waun*, University of Wisconsin anesthesiologist; and *Dr. Robert O. Johnson* of the Wisconsin clinical oncology department, all of Madison, addressed members of the American Medical Association at its annual convention in Atlantic City, N. J., late in June.

Doctor Forster explained the latest word on conditioning therapy in epilepsy which has been used successfully at the University of Wisconsin.

Doctor Waun reported on a rarely observed problem following general anesthesia—temporary deafness—which may occur in patients of all age groups undergoing any kind of surgery.

Doctor Johnson reported results of his work on the intra-arterial infusion method of cancer chemotherapy.

Dr. Sanford Named Plant Doctor

Dr. L. L. Sanford, Hillsboro, is now the resident physician at the hospital at the Badger Army Ammunition plant near Baraboo. He accepted the position on a temporary basis and during his tenure there his Hillsboro office will be closed.

Dr. Val Adamski Opens Practice

Dr. Val D. Adamski, a former Seymour resident, has returned to Seymour to begin general surgery practice in association with the Hittner Clinic. Doctor Adamski graduated from the Marquette University School of Medicine and has been training in general surgery at the Cook County Hospital, Chicago, for the past five years.

Dr. Drew Reelected President

Dr. Frank E. Drew, Milwaukee, was recently reelected president of the Wisconsin State Board of Health at the annual election.

Dr. Lanier Attends Convention

Dr. Patricia Lanier, Kewaunee, recently attended the national convention of the National Association of American University Women. She is a national officer and attended the board meetings and presided over the Northeast-Central Region banquet. The convention was held in Miami Beach, Fla.

Dr. McGill Receives Outstanding Citizen Award

Dr. James W. McGill, Superior, recently was the recipient of the 1966 "Outstanding Citizen of the Year" award. Doctor McGill was selected from a list of many persons submitted by the public to a committee appointed by the B'nai B'rith of Superior who sponsored the award.

Doctor McGill served as president and secretary of the Douglas County Medical Society, has been a member of the Interurban Academy of Medicine, and is a member of the American College of Surgeons,

---

Physicians whose names appear in italics are members of the State Medical Society.

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DOSAGE:

1 or 2 teaspoonfuls or 1 or 2 tablets 3 times a day before meals. The feeling of warmth and tingling of the skin is a desirable effect. If this reaction is too pronounced reduce dosage.

CONTRAINDICATIONS:

There are no known contraindications.

SUPPLIED:

8 oz. bottles and bottles of 100 chew-tabs.

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PHYSICIAN NEWS *continued*

Central Association of Obstetricians and Gynecologists, as well as his local, state and national medical societies. Chief of Staff at both St. Mary's and St. Joseph's hospital, he has had many affiliations with civic groups.

Doctor McGill received his medical degree from St. Louis University in 1925 and began his practice of medicine in 1926 in association with his father in Superior. His practice has spanned over a period of 40 years.

Dr. Graber Retires as Health Officer

Dr. Rex Graber, Chippewa Falls, recently announced his retirement as district health officer for the State Board of Health. He has held this position for 16 years. His duties will be partially filled by *Dr. John Van Susteren* of the La Crosse District. Doctor Graber received his medical degree from Rush Medical College in 1923 and interned at Kings County Hospital in Brooklyn, N. Y. He joined a clinic at Bismarck in 1925 and practiced there until 1931 when he moved to Stanley and set up practice. Doctor Graber moved to Chippewa Falls in 1946 and in 1951 he was named district health officer.

Doctor Graber was given a year's leave of absence and attended the Public Health School at the University of Minnesota and has been certified by the American Board of Preventive Medicine as a specialist in public health. He is a fellow in the American Public Health Association.

Dr. Morgan Guest Speaker

Dr. S. F. Morgan, Milwaukee, recently was the guest speaker at a public heart forum held at Oconto Memorial Hospital. Doctor Morgan, associate professor of pediatrics at Marquette University School of Medicine, discussed "Rheumatic Fever: Cause, Effect and Treatment." Doctor Morgan together with Dr. William C. Boake, Madison internist at University Hospitals, examined about 25 congenital and rheumatic heart disease patients who had been referred to the clinic by their physicians.

Dr. Kaner Elected to Academy

Dr. S. L. Kaner, Two Rivers, recently was elected to active membership in the American Academy of General Practice.

Dr. Tydrich Elected to Academy

Dr. James J. Tydrich, Richland Center, has been elected to active membership in the American Academy of General Practice.

Dr. Schrang Guest Speaker

Dr. Eugene Schrang, Neenah, recently was the guest speaker at the Kiwanis Club meeting in Fond du Lac. Doctor Schrang, a certified plastic surgeon associated with the Theda Clark Hospital in Neenah, used color slides to illustrate what can be accomplished through plastic surgery.

Dr. Garner Assumes New Position

Dr. Lawrence L. Garner resigned as director of the Marquette University Glaucoma Referral Center in October 1966. He is now full time with the Veterans Administration, serving as ophthalmologist and assistant chief, outpatient service. A tonography laboratory has been developed in the Veterans Administration's Outpatient Service for the investigation and study of glaucoma.

Dr. Wasserburger Heads Heart Unit

Dr. Richard H. Wasserburger, Madison, has been appointed chairman of the physician education committee of the Wisconsin Heart Association. Doctor Wasserburger is chief of cardiology at University Hospitals. A member of the board of directors of the association for two years Doctor Wasserburger has served on the research committee since 1962. He also has worked on the rheumatic fever clinic team since 1954.

Dr. Najat Joins Monroe Clinic

Dr. Hushang Najat, an orthopedic surgeon, has joined the staff of The Monroe Clinic. Doctor Najat, a native of Marand, Iran, received his medical degree in 1957 from the Medical School of Tabriz, Iran. He interned at Loretto Hospital, Chicago, Ill., and has served residencies in several hospitals in the Chicago area. For the past three years, Doctor Najat has been associated in practice with two orthopedic surgeons in Chicago. Doctor Najat has held teaching appointments at St. Elizabeth Hospital School of Nursing and at the Northwestern University School of Medicine in Chicago.

Dr. Hickey Reappointed to Surgery Department

Dr. Robert C. Hickey has been reappointed as chairman of the surgery department at the University of Wisconsin Medical School, it was announced recently by *Dr. Peter L. Eichman*, dean. Dr. D. B. Slautterbach, anatomy department, will succeed *Dr. Otto A. Mortensen* who is retiring; and *Dr. A. A. Siebens* will be chairman of the newly-formed department of rehabilitation medicine.

Dr. Porter Guest Speaker

Dr. Gerald Porter, a Marshfield Clinic pediatrician, recently spoke on "Child Abuse" before a regional child abuse seminar held in Green Bay. Doctor Porter told his audience that physicians, psychiatrists, and social workers have just begun their research on the "battered child syndrome."

Dr. Hebble Joins Beloit Clinic

Doctor Hebble

Dr. William M. Hebble, recently joined the Beloit Clinic. Doctor Hebble, an orthopedic surgeon, is a native of Rock Island, Ill. He graduated from University of Illinois College of Medicine in 1960, served in the United States Army at Fort Jackson, S. C., and recently finished his residency in orthopedic surgery at Indiana University.

Dr. Drew Appointed Director

Dr. Frank E. Drew recently was appointed a director of The Medical Society of Milwaukee County it was announced by the president, *Dr. Christopher R. Dix*. Doctor Drew replaces *Dr. Robert S. Haukohl* who resigned to accept an appointment as an associate professor of pathology at the University of Miami Medical School.

Staff Elects Officers at St. Joseph's Hospital

New officers were elected recently by the staff at St. Joseph's Hospital, Chippewa Falls, at the annual meeting. They are: *Dr. B. J. Haines*, Cadott, president; *Dr. R. L. Hendrickson*, Cornell, vice-president; and *Dr. C. T. Bowe*, Cadott, secretary. Also appointed as member of the board was *Dr. F. J. Brown*, Chippewa Falls, ex-officio president.

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437–0442

PHYSICIAN NEWS *continued*

Dr. Grinvalsky Named Head of Pathology

Dr. Henry T. Grinvalsky, formerly a physician at Stevens Point, recently accepted the position as director of pathology at the Catholic Medical Center of the Diocese of Brooklyn and Queens, New York. Doctor Grinvalsky was the pathologist at St. Michael Hospital in Stevens Point from 1956 to 1963. Before accepting the position at the Catholic Medical Center he was a member of the faculty at Creighton University School of Medicine in Omaha, Neb.

Dr. Batzner Guest Speaker

Dr. David J. Batzner, Sheboygan, recently was the guest speaker at the June meeting of the Jaycettes in Sheboygan. Doctor Batzner discussed cancer.

Dr. Schott Heads Rotary Club

Dr. Edward G. Schott, Sheboygan, recently was installed as president of the Sheboygan Rotary Club. He has been associated with the Sheboygan Clinic since 1941.

Dr. Hoffman Honored for Community Service

Dr. Leo A. Hoffman, Campbellsport, was recently honored at an appreciation dinner for his 50 years of community service. Doctor Hoffman was commended not only for his service as a physician to the community but also for his interest in the welfare of Campbellsport by participating in community activities.

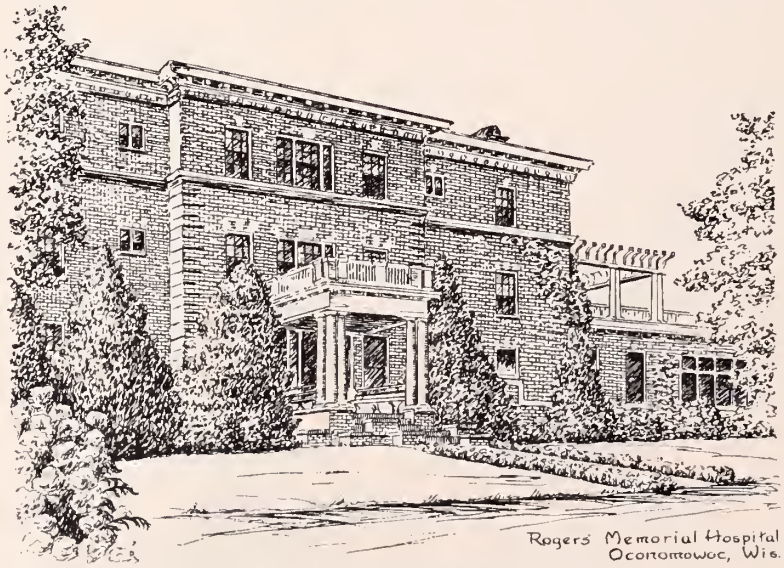
Doctor Hoffman earned his degree of medicine at the Marquette University School of Medicine and interned at Milwaukee Hospital. He was honored at Marquette University this spring as a fifty-year graduate, and the State Medical Society of Wisconsin recognized him for his fifty years of medical service at its annual convention held in Milwaukee this year.

Dr. Peterson Honored at Rotary Club

Dr. M. G. Peterson, Lake Mills, president of the Rotary Club, recently was honored at a "memory of life" program for his service to the community as a family and community physician for more than 42 years. Doctor Peterson was presented with gifts and *Dr. E. J. Netzow*, an associate of Doctor Peterson for over twenty years, offered verbal tribute to "a doctor of character, intelligence, and integrity."

Dr. Houfek Volunteers Services

Dr. Edward E. Houfek, Sheboygan, has volunteered one month of service to the U.S. Caribbean Aid to Mental Health Incorporated. Doctor Houfek will be taking his family with him and also a supply of medicine donated by the Nurses' Aide Association of Memorial Hospital.



MEDICAL STAFF

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Medical Director
EUGENE B. FRANK, M. D.
LOREN J. DRISCOLL, M. D.
THOMAS J. GORAL, M. D.
JOHN J. O'HARA, M. D.
EARL F. WEIR, M. D.
LEROY WAUCK, Ph. D.
Clinical Psychologist
ROBERT TESTIN, Ph. D.
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COUNTY SOCIETY PROCEEDINGS

DANE

There were no regular meetings of the Dane County Medical Society during July and August. The next regular meeting will be the Society's annual golf tournament Wednesday, September 13, at the Stoughton Country Club.

New members are *Dr. Donald A. Daugherty* who is associated with the Dean Clinic, specializing in internal medicine; *Dr. Willis G. McMillan*, an otolaryngologist practicing in Madison; and *Dr. Harlan M. Smith*, associated with the Division of Mental Hygiene of the State Department of Public Welfare.

KENOSHA

A grant from the Kenosha County Medical Society's Foundation was presented recently to support a summer speech therapy program for Kenosha school children. This is the tenth year for the summer program. Because of school budget cuts, part of the funds were not available this year so the medical society's foundation provided the money.

MILWAUKEE

"Frontiers in Medicine 1967" will be the theme of this year's Milwaukee Medical Conference to be held at Coffey Auditorium, Milwaukee County General Hospital, November 9–10.

The Society is planning a television program on air pollution as its contribution to National Community Health Week in October.

The 40th Annual MSMC golf tournament was held August 8 at Hoffmann's River Oaks Country Club, Mequon.

TREMPEALEAU–JACKSON–BUFFALO

The July 25 meeting of the Tri-County Medical Society was held at the Green Meadows Supper Club near Blair. A movie on ano-rectal cancer was shown by a representative of the American Cancer Society.

* * *

SOCIAL SECURITY speakers, films, and literature are available upon request to any local social security office.

Physicians whose names appear in italics are members of the State Medical Society.

SCHEDULE—ORTHOPEDIC FIELD CLINICS

July 1, 1967–December 31, 1967

STATE DEPARTMENT OF PUBLIC INSTRUCTION

BUREAU FOR HANDICAPPED CHILDREN—CRIPPLED CHILDREN DIVISION

MADISON, WISCONSIN 53703

Location	*Date*
Ashland	August 9 and 10
Stevens Point	August 16
Manitowoc	August 30 and 31
Superior	September 14
Racine	September 20 and 21
Eau Claire	September 27 and 28
Kenosha	October 4 and 5
La Crosse	October 18 and 19
Chippewa Falls	October 25 and 26 (tentative)
Rhinelander	November 1 and 2
Sheboygan	November 8 and 9

FOR: Clinics conducted by the Crippled Children Division of the Bureau for Handicapped Children are for persons under 21 years of age, who are referred by their family physician for orthopedic diagnosis and consultation. The reports of the examinations are then sent to the referring physician following the clinic.

REFERRAL FORMS: Forms for the purpose of referral may be obtained from the Bureau for Handicapped Children and should be requested well in advance of the clinic date. Medical referral forms are made up for the individual clinic so when requesting same be sure to state approximately how many forms are needed and for which clinic or clinics. It is important that we know well in advance the number of persons desiring clinic service so the case load will not exceed clinic facilities.

CLINIC APPOINTMENT: Families who return the signed referral form will be notified of the date and hour of their appointment a few days before the clinic. Parents and physicians are invited to attend the clinic with the child.

ADDRESS CORRESPONDENCE: Bureau for Handicapped Children, 126 Langdon Street, Madison, Wisconsin 53703.

SPECIALTY SOCIETY PROCEEDINGS

SMS Section on Otolaryngology

The following officers have been elected for the State Medical Society's Section on Otolaryngology: chairman, *Dr. J. K. Scott* of Madison; secretary, *Dr. Harold Manhart* of Madison; delegate, *Dr. Watson B. Larkin* of Eau Claire; and alternate delegate, Doctor Scott.

Milwaukee Orthopaedic Club

At the annual meeting of the Milwaukee Orthopaedic Club, the officers for the year were elected as follows: president, *Dr. Louis Kagen;* president-elect, *Dr. James Groh;* secretary, *Dr. Paul Jacobs;* and treasurer, *Dr. E. Kenneth Rath.*

Wisconsin Society of Internal Medicine

See page 7 of this issue for WSIM annual meeting and scientific program details: September 15 and 16 at Land O'Lakes.

Physicians whose names appear in italics are members of the State Medical Society.

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Wisconsin Medical Assistants

The twelfth annual meeting of the Wisconsin State Medical Assistants Society was held June 9–11 at the Park Motor Inn in Madison. The theme of the meeting was "Winning Ways for Working Days." Climax of the meeting was the installation of the newly-elected officers: president, Miss Donna Schultz, Menasha; vice-president, Miss Phyllis Schirmer, Milwaukee; president-elect, Mrs. Jane Staszewski, C.M.A., Big Bend; recording secretary, Mrs. Joyce Ptaschinski, Beaver Dam; treasurer, Mrs. Lucille Skolaski, Madison; speaker of the House, Mrs. June Gillette, Sheboygan; and vice-speaker of the House, Mrs. Mildred Gedakovitz, Waukesha.

Delegates elected to attend the national convention in Los Angeles in October are: Miss Donna Schultz, Menasha, and Mrs. Mildred Gedakovitz, Waukesha.

Wisconsin State Board of Health

Appointments to two advisory councils were made by the Wisconsin State Board of Health at the July board meeting. All of the appointments were for four-year terms expiring Aug. 26, 1971.

Named to the Advisory Council for the State Plan for Construction of Mental Health Centers were: John W. Melcher, director of the Bureau for Handicapped Children, State Department of Public Instruction, Madison; Rev. Arcadius Maroti, director of the De Paul Rehabilitation Center, Milwaukee; Kirby Hendee, Hardware Mutual Insurance Company, Stevens Point.

To the Advisory Council for the State Plan for Construction of Facilities for the Mentally Retarded the following were appointed: John W. Melcher; Donald Tofte, Racine; Rev. Philip Heslin, director of the Bureau of Catholic Charities of Superior.

Planned Parenthood Association

The Planned Parenthood Association of Milwaukee opened a family planning clinic July 7 in the Waukesha YWCA. The clinic will operate for low income families under sponsorship of the Waukesha County Council for Child Welfare and the YWCA. Physicians, registered nurses, and professional social workers will conduct the sessions.

Dane County Medical Assistants

Mrs. Jane Staszewski of Big Bend, president-elect of the Wisconsin State Medical Assistants Society, installed new officers of the Dane County Medical Assistants Society at a meeting June 27 at the Cuba Club in Madison. New officers are: Barbara Schumann, president; Jessie Birkholz, president-elect; Lucille Skolaski, secretary; and Patricia Pagliaro, treasurer.

Manitowoc Medical–Legal Seminar

Relationships between the medical and legal professions were discussed by Circuit Judge F. H. Schlichting in a talk at a joint dinner meeting of the Manitowoc Bar Association and Manitowoc County Medical Society at the Sorge Charcoal House June 13.

About 65 doctors and lawyers attended. Attorney Arden Muchin was master of ceremonies. *Dr. T. H. Rees*, president of the medical society, and Attorney Victor Miller, president of the bar association, presided at the meeting.

Physicians whose names appear in italics are members of the State Medical Society.

PARAMEDICAL ANCILLARY GROUPS

Marquette University School of Medicine

John W. Cowee, vice-president for business and finance at Marquette University, has been named to the newly created position of vice-president of the MU School of Medicine. According to Father John P. Raynor, MU president, "this gives us an organizational structure to coordinate effectively the activities of the medical school and the university. It will also produce the ingredients for strengthening health care services for the community."

Mr. Cowee is a member of the board of directors of Cutter Laboratories, Berkeley, Calif., and for six years was a member of the board of trustees of California Physicians' Service. Shortly after coming to Marquette in 1966, he was appointed to the board of directors of the medical school, and elected board secretary. A native of Wausau, Mr. Cowee received his bachelor's, master's, and doctor's degrees, and a law degree, from the University of Wisconsin.

La Crosse Medical–Legal Seminar

Improved ways of handling the problems of mentally ill persons brought into court still are needed. This theme was sounded in the opening talk at the medical–legal seminar sponsored by the La Crosse County Bar Association and La Crosse County Medical Society.

About 35 professional persons met in June at the Cerise Club for the two-hour session and dinner which followed.

Dr. Anton Haidinyak, La Crosse psychiatrist, traced the history of law and court trials affecting the mentally ill. *Dr. John Shields*, also a La Crosse psychiatrist, explained problems psychiatrists have in presenting testimony on sanity or insanity in court.

Alastair Burnett, chief clinical psychologist at the La Crosse County Guidance Clinic, described several character disorders and emphasized the need for good diagnosis and evaluation of an individual's problems and needs in relation to difficulties with the law.

District Attorney Burleigh Randolph said attorneys can be of great assistance to psychiatrists in their presentation of testimony.

William Skemp, an attorney, said defense attorneys need to consider "what is in the best interest of the client" in using "insanity" as a defense.

County Judge Eugene A. Toepel said courts have an interest in the welfare of both the defendant and society. *Dr. John B. Lefsrud*, La Crosse psychiatrist, pointed out the need for collaboration between psychiatrists and courts.

Wisconsin Nurses Association Convention

The Wisconsin Nurses Association will hold its annual convention on October 4–6 at the Sheraton–Schroeder Hotel, Milwaukee. The theme is "Charting Our Progress."

The convention speakers and their topics will include:

Luther Christman, R.N., Ph.D., director of nursing at Vanderbilt University School of Nursing and Hospital, Nashville, Tenn., "Expanding the Scope of Nursing Services."

Lucille Notter, R.N., Ed.D., New York, "Progress in Preparation for Nursing Practice," to be followed by a panel on nursing education in Wisconsin. Miss Notter is editor of NURSING RESEARCH.

Ruth Freeman, R.N., Ed.D., professor of public health administration, The Johns Hopkins University, Baltimore, Md., "Health Is a Community Affair."

Julia C. Thompson, R.N., M.S., director of the Washington, D.C. office of the American Nurses' Association, who will bring greetings from the national group and be part of a panel reacting to Doctor Freeman's talk.

Kathryn F. Clarenbach, Ph.D., director of university education for women, University Extension, University of Wisconsin, Madison, "Making the Most of Your Talents."

A forum on economic security will be presented on Wednesday and Thursday evenings.

The highly successful nursing clinics will again be held on Thursday afternoon. This year the topics will include "Pathways to Learning," "Caring of the Dying Patient," "Strokes: Frustrations—Irritations—Communications," "Nursing Care Plans," "Job Analysis—How to Develop a Job Description," "Care of the Trauma Patient," and "An Approach to Nursing."

Mrs. Margaret Dykeman, R.N., Kenosha, is president of the Wisconsin Nurses Association. The following registered nurses are candidates for the office of president-elect, to be filled at this convention: Betty Joan Ford, Milwaukee; Mrs. Mary L. McCabe, Fond du Lac, and Sister M. Renelle, Green Bay.

All Wisconsin nurses, regardless of whether they are members of the association, are invited to attend the convention. Nursing students are also welcome.

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Therapeutic Effects: Stiffness and pain may diminish within 2 days, and full mobility may be restored within a week. These effects are obtained with oxyphenbutazone alone or combined with physiotherapy or local hormonal injections. The drug is usually well tolerated and does not affect pituitary-adrenal function or immune response.

Contraindications: Edema; danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia. The drug should not be given when the patient is senile or when other potent drugs are given concurrently.

Warning: If coumarin-type anticoagulants are given simultaneously, watch for excessive increase in prothrombin time. Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea, sulfonamide-type agents and insulin. Carefully observe patients receiving such therapy. Use with great caution in the first trimester of pregnancy.

Precautions: Obtain a detailed history and a complete physical and laboratory examination, including a blood count. The patient should be closely supervised and should be warned to report immediately fever, sore throat, or mouth lesions (symptoms of blood dyscrasia); sudden weight gain (water retention); skin reactions; black or tarry stools or other evidence of intestinal hemorrhage. Make regular blood counts. Discontinue the drug and institute countermeasures if the white count changes significantly, granulocytes decrease, or immature forms appear. Use greater care in the elderly and in hypertensives.

Adverse Reactions: The most common are nausea, edema and drug rash. The drug has been associated with peptic ulcer and may reactivate a latent peptic ulcer. Infrequently, agranulocytosis, or a generalized allergic reaction may occur and require withdrawal of medication. Stomatitis, salivary gland enlargement, vomiting, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported but cannot definitely be attributed to the drug. Thrombocytopenic purpura and aplastic anemia may occur. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hyperglycemia, hepatitis, jaundice, and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently. Moderate lowering of the red cell count due to hemodilution may occur.

Dosage in Painful Shoulder: 600 mg. daily in divided doses for 2 to 3 days; 300 mg. daily thereafter. Usual duration of therapy: 2 to 7 days.

Availability: Tablets of 100 mg. 6562-VI(B)R

For complete details, please refer to full prescribing information.

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OBITUARIES

Dr. Arthur H. Knudson, 70, who had practiced in Milwaukee for over 40 years, died May 17, 1967, in Milwaukee.

Born in Evansville, he was graduated from the University of Minnesota in 1924 and interned at Columbia Hospital in Milwaukee. Doctor Knudson served in the Navy in World War I and in 1925 was commissioned in the Army Reserves.

Doctor Knudson was a member of the Medical Society of Milwaukee County, State Medical Society of Wisconsin, and the American Medical Association.

Surviving are his widow, Lois; and a daughter Mrs. John Damron.

Dr. John A. Litzow, 60, Stevens Point, died May 23, 1967, in Stevens Point.

Doctor Litzow, eye, ear, nose and throat specialist, graduated from Colorado University in 1931 and interned at St. Joseph's Hospital in Ashland in 1931 and 1932. He took his residency at Illinois Eye and Ear Infirmary and at Milwaukee County General Hospital from 1935 to 1937. Before coming to Stevens Point, Doctor Litzow had practices in Elderon and Milwaukee.

Doctor Litzow, at the time of his death, was president of the Portage County Medical Society. He was also a member of the State Medical Society of Wisconsin and American Medical Association.

Surviving are his widow, Florence; a daughter, Mrs. Phillip Pelland; and three sons, Dr. John, Robert, and Thomas of Milwaukee.

Dr. Irving E. Schiek, Sr., 79, a retired Rhinelander physician, died May 27, 1967.

Doctor Schiek was graduated from the Marquette University School of Medicine in 1908 and started his practice in Rhinelander in 1910. He was a member of the Oneida–Vilas County Medical Society, State Medical Society of Wisconsin, and the American Medical Association.

He is survived by a son, Dr. Irving E., Jr., who heads the clinic founded by his father, and a sister, Miss Lillian Schiek, Milwaukee.

Dr. Mary N. Bielefeld, 61, a physician for the county and the city of Milwaukee for more than 25 years, died May 31, 1967, in Milwaukee.

Born in Milwaukee, she was graduated from the Marquette University School of Medicine in 1934 and interned at Milwaukee County General Hospital.

She worked as a physician for the old Milwaukee county dispensary emergency unit from 1934 until 1940. She then began working for the city in 1942 as a school physician in the health department. She later served the department as a child welfare clinic physician and finally as a district physician. She retired in 1960 from this last position.

Doctor Bielefeld was a member of the Medical Society of Milwaukee County, State Medical Society of Wisconsin, and American Medical Association.

Surviving are her four children, Mrs. James Fletcher, Bloomington, Ind., Edward A., Jr., Robert, and Mary Alice of Milwaukee.

Dr. Irene T. Stemper, 80, Oconomowoc, died June 11, 1967, in Oconomowoc.

Doctor Stemper was born in Milwaukee and graduated from the Marquette University School of Medicine. She was a past president of the Waukesha County Medical Society, and a member of the State Medical Society of Wisconsin and American Medical Association.

Surviving are her husband, J. Alex; a daughter, Mrs. Stanley Stone, Chagrin Falls, Ohio, and two sons, Dr. John A. Stemper of Milwaukee, and Michael of Oconomowoc.

Dr. Mason S. LeTellier, 46, Green Bay, died June 15, 1967, in Green Bay.

Doctor LeTellier graduated from Marquette University School of Medicine in 1946 and interned at Milwaukee County General Hospital. After serving a residency in general surgery at Milwaukee Hospital, he spent two years in Korea as a surgeon, with rank of captain with the 25th Division. Doctor LeTellier was chief of staff of St. Mary's Hospital in Green Bay. He was a diplomate of the American Board of Surgeons and a fellow of the American College of Surgeons.

An outdoorsman, his hobbies were golfing, skiing, and bird watching. He received prizes at the Paine Art Center, Oshkosh, in 1957 and 1959, for his carvings of wild duck decoys. Doctor LeTellier was a former Brown County golf champion and a runner-up for the Northeastern Wisconsin championship.

He was a member of the Brown County Medical Society, State Medical Society of Wisconsin, and American Medical Association.

Surviving are his widow, Mary; two daughters, Mary, a student at the University of Denver, and Sue Ann, at home; and a son, Mason John, at home.

Dr. Edgar B. Elvis, 81, former Medford physician, died June 24, 1967, in Madison.

Doctor Elvis graduated from Marquette University School of Medicine in 1910 and practiced in San Antonio, Tex., before returning to Medford where he practiced for 50 years. He was a medical officer in World War I.

Surviving are his widow, Bernice; and a daughter, Mrs. Donald Van Kleeck, Madison.

Dr. Spencer D. Beebe, 97, Sparta, died June 25, 1967, in the Monroe County Infirmary where he had resided for the past few years.

Doctor Beebe graduated from Rush Medical College in 1896 and practiced in Aurora, Ill., and Elroy before returning to his hometown of Sparta where he had practiced for more than 60 years. In 1949, he was made a Life Member of the State Medical Society in recognition of high achievement and long and outstanding meritorious service. In 1950, Doctor Beebe was designated "Wisconsin's Country Doctor of the Year" and was guest of honor during the

special "Doctor Beebe Day" celebration held in Sparta. Music and singing were among the doctor's avocations and during World War I, for the benefit of soldiers at Camp McCoy, he organized and conducted "Services under the Trees," an interdenominational religious program held each Sunday during the summer. The services continued for 37 years.

Doctor Beebe was a member of the Monroe County Medical Society, the State Medical Society of Wisconsin, of which he served nine years as a councilor of his district, and American Medical Association.

Surviving are one son, Dr. DeWitt C. Beebe, Sparta; a foster son, Orville Evenson, Waunakee; three daughters, Mrs. John Omernik, Mrs. Claire VanAntwerp, and Mrs. Edmund Searing, all of Sparta.

Mike Flaherty in *MILTON & MILTON JUNCTION COURIER*, MILTON JUNCTION, July 20, 1967

To a Great Man . . .

Any words we write in this column (Current Comment) will fall far short of expressing fully our regard for Dr. Milton Davis who died Wednesday (July 19, 1967) in the service of his fellow men.

Of very few men do these words more aptly apply: The world is a far better place for his having lived in it.

Our sincerest hope is that his ideals of service, his unflagging interest in his community, his warm personality and his enthusiasm have been an inspiration to many potential Dr. Davises in this world.

Editorial from JANESVILLE GAZETTE, July 21, 1967

Dr. Milton D. Davis

The life story of most country doctors are filled with the joys, sorrows, tragedies and pathos of human kind, and so it was with Dr. Milton D. Davis. His service to the Milton community was marked with a personal interest in people, and every day brought demands upon him that often would tax an ordinary man.

He was the grandson of a doctor, and his father combined medicine with the ministry and also printing and publishing. Though he was a country doctor and subject to all the unreasonable demands of such service, he was an organization man and was active in many causes. He was generous with both his money and his time.

"Milt" Davis enjoyed life and people. His light step and quick smile were engaging and he endeared himself to patients and the community. He was a good listener, but never revealed much of his own problems.

The larger community of Milton and the area will not soon find a replacement for "Doc" Davis.

Dr. Milo M. Scheid, 83, Rosendale, died June 25, 1967, in Ripon.

Doctor Scheid was a graduate of Rush Medical College, Chicago, and had practiced medicine in the Rosendale community since 1909.

Doctor Scheid was a former member of the Fond du Lac County Medical Association and at one time served as its president. He formerly belonged to the State Medical Society of Wisconsin and American Medical Association.

Surviving are his widow, Harriet; one daughter, Mrs. Alfred Grimm, Green Lake; and one son, Myron of Ripon.

Dr. Harold Guzzo, 53, Washburn, died July 12, 1967, in Washburn.

Born in Sicily, Doctor Guzzo served in the Air Force during World War II and practiced in New York until he moved here in 1947. At the time of his death, Doctor Guzzo was the medical director at Washburn hospital and was also the medical examiner at the Barksdale plant of the Du Pont Powder Company.

Doctor Guzzo was a member and current president of the Tri-County Medical Society, and a member of the State Medical Society of Wisconsin and the American Medical Association.

Surviving are his widow, Janet; and three daughters, Jana, Dianne and Sandra.

Dr. Milton D. Davis, 64, prominent Milton physician and a member of the Council of the State Medical Society of Wisconsin, died July 19, 1967, in Milton.

Born in West Edmonston, N. Y., Doctor Davis received his medical degree from Northwestern University in 1931 and interned at West Suburban Hospital, Oak Park, Ill. He started his medical practice in Milton in 1932 and served in the United States Army from 1942 to 1946. After completion of military service, he returned to Milton and resumed his practice.

Doctor Davis was past president of the Mercy Hospital Medical staff in Janesville and past president of the Rock County Medical Society. Active in the affairs of the State Medical Society of Wisconsin, he was a member of the Commission on Medical Care Plans, chairman of the Planning Committee of the Council, member of the Executive Committee of the Council, and an advisor to the Wisconsin State Medical Assistants Society.

In 1957, he was appointed one of 13 general vice-chairmen of the fund drive to establish the Medical Museum of Wisconsin on the site of the second Fort Crawford in Prairie du Chien, a project sponsored and completed under the direction of the State Medical Society. Doctor Davis was also a member of the American Medical Association.

Surviving are his widow, Jessie; a son, Milton Jr., with the Marine Corps in Camp Lejune, N. C.; and a grandson, Christopher Doland.

MEMBERSHIP REPORT AS OF JUNE 29, 1967

SOCIETY RECORDS

NEW MEMBERS

Batsleer, R. L., 141 South Pine St., Burlington 53105
Conklin, John W., Waukesha Memorial Hospital, Waukesha 53186
Daugherty, Donald A., 1313 Fish Hatchery Road, Madison 53715
McMillan, Willis G., 1605 Monroe St., Madison 53711
Mercer, Wayne C., 220 Seventh Ave., West, Ashland 54806
Najafzadeh, Moktar, 407 North Water St., Sparta 54656
Smith, Harlan M., 4701 Mineral Point Rd., Madison 53705

CHANGES OF ADDRESS

Bond, John T., Greenfield, to 5600 S. 121st St., Hales Corners 53130
Brooks, Jerome C., Aberdeen Proving Grounds, Maryland, to 36th Evacuation Hospital, APO San Francisco 96291, Calif.
Bunkfeldt, Frederick, Jr., 525 E. Wells St., Milwaukee 53202
Clark, D. M., Beloit, to 911 Blackhawk Blvd., Rockton, Ill. 61072
Cohen, D. A., 1011 North Main, Edgerton 53534
Egan, W. J., 525 E. Wells St., Milwaukee 53202
Falecki, Julian, Milwaukee, to 10125 West North Ave., Wauwatosa 53226
Feierabend, Theodore C., Madison, Christian Medical College, Ludhiana, Punjab, India
Gohdes, Paul N., Madison, to Theda Clark Memorial Hospital, Neenah 54956
Grab, John A., Sun Prairie, to 2126 Chadbourne Ave., Madison 53705
Harned, Roger K., Cudahy, to 2302-A Angus Rd., Charlottesville, Va. 22901
Harper, Samuel B., 3 Bayside Drive, Madison 53703
Kuhs, M. L., 2010 Wisconsin Street, Oshkosh 54901
McNamara, P. J., 525 East Wells St., Milwaukee 53202
Meli, James Vincent, 400 Ceape Ave., Oshkosh, 54901
Meloy, Gisela M., Milwaukee, to 1688 Chimney House, Reston, Va. 22070
Mountain, D. C., 525 East Wells St., Milwaukee 53202
O'Neill, P. B., 525 East Wells St., Milwaukee 53202
Raneses, Jovencio L., 312 New Castle Way, Madison 53704
Rosin, Louis R., 318–21st Avenue East, Superior 54880
Schwindt, Walter D., Madison, to 159 East Sammomish Road N., Redmond, Wash. 98052
Scott, C. Malcolm, 318–21st Avenue East, Superior 54880
Sellers, Robert L., 318–21st Avenue East, Superior 54880

REMOVED FROM MEMBERSHIP

Bandelin, Valerie R., Kenosha County, removed per County Secretary.
Collins, Richard A., Milwaukee County, resigned.
Luck, Allan, Milwaukee County.
Reynolds, James F., Brown County, transferred to Minnesota.
Voytek, Joseph, Jefferson County, resigned.

DEATHS

Stemper, Irene T., Milwaukee County, June 11, 1967.
Le Tellier, Mason S., Brown County, June 15, 1967.
Elvis, Edgar B., Nonmember, June 24, 1967.
Beebe, Spencer D., Monroe County, June 25, 1967.

CHILDREN'S CONSULTATION SERVICE ESTABLISHED

Beginning July 1, 1967 a Children's Consultation Service at the Mendota and Winnebago State Hospitals replaced the program of the Diagnostic Center. This is a result of the legislature objecting to the high cost of operating the Center, but approving that kind of program. The Consultation Service at those two hospitals is in addition to their present children's treatment programs. It is contemplated each hospital will have 20 beds allotted to the new service. The Diagnostic Center has a rated capacity of 55 and an average population of 35.

The organizational structure of the new setup calls for a central office staff to coordinate and implement Children's Consultation Service as well as the entire area of children's psychiatric service.

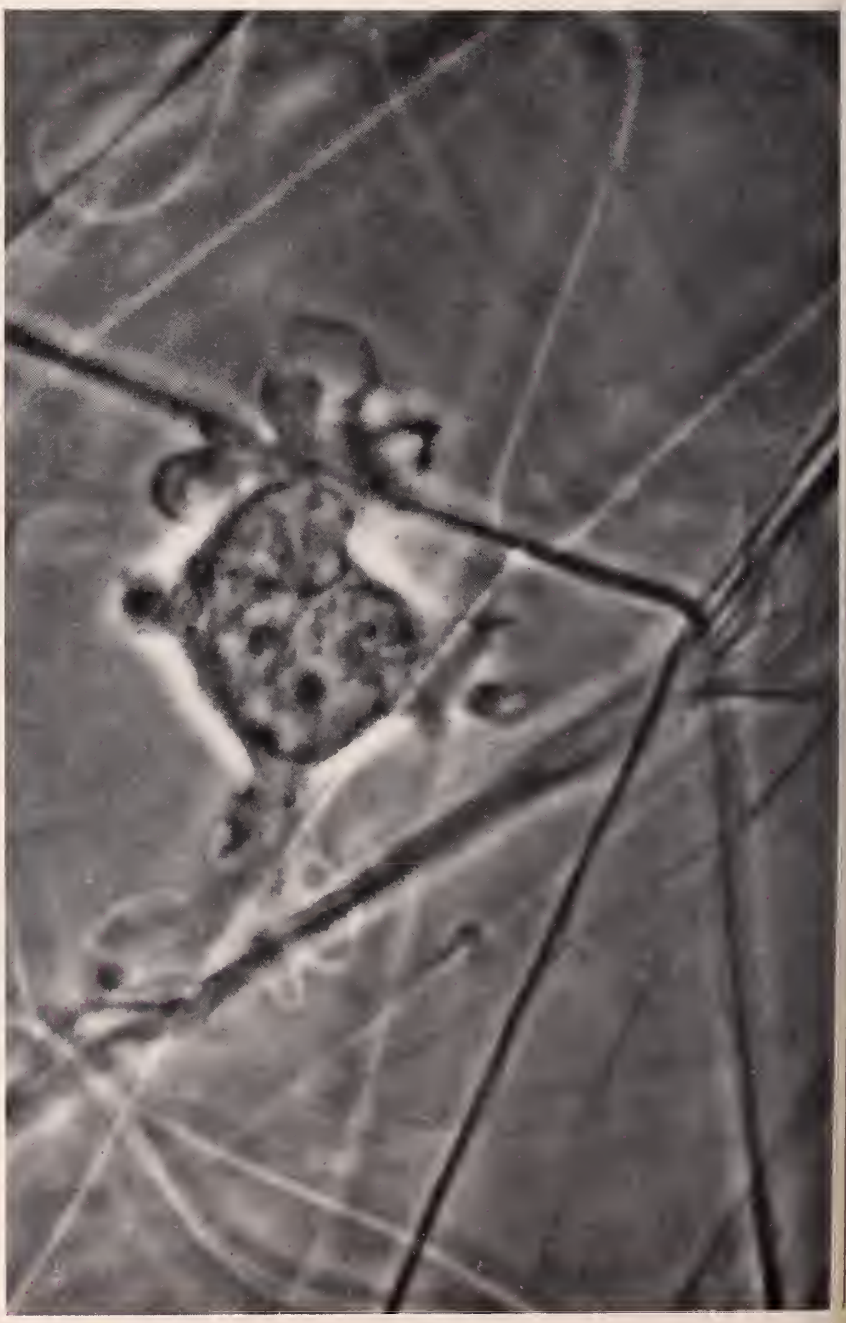
The purpose of the new service is to provide for the temporary residence and the identification of the emotional problems of children referred from juvenile courts, the institutions and services under the Department of Public Welfare, University Hospitals, county and private child welfare agencies, schools for the deaf and visually handicapped, and mental health facilities within the state; to promote development of preventive mental health services to children in communities by participating in the training of mental health personnel, by demonstration of methods of evaluation, care and treatment, by assisting in assessment of community services, by developing effective coordination between the institution and the community; and by offering services when community resources need to be supplemented.

INFLAMMATION: A cellular fight for life

A SYNTEX REPORT based on recently developed hypotheses about topical corticosteroids, including the cellular theories of inflammation by Thomas F. Dougherty, Ph.D., University of Utah.

You are looking at a fibroblast fighting for life. This cell—one of the most common found in connective tissue—has literally been poisoned by cytotoxins released from other cells that have ruptured. Soon, if the abnormal activity of this fibroblast does not cease, it, too, will rupture and die—one more casualty in the inflammatory wave of destruction precipitated by injury.

Until a short time ago no one had ever witnessed such a scene at the cellular level. Now, through advanced cinemicrographic techniques, it is possible to view and photograph the inflammatory process as produced experimentally in living animal tissue. This method permits new insight into the mechanism of inflammation and the role of corticosteroids in therapeutic management. Equally important, these techniques shed new light on factors that may make one corticosteroid more effective than another—factors that can be correlated with other chemical, biologic, and clinical parameters



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Representative Clinical Results with Synalar*

Efficacy Documented in over 4,000 Patients

Condition	Number of Publications	Number of Patients	Significant Improvement†
Contact Dermatitis	27	750	713
Eczematous Dermatitis	21	472	409
Seborrheic Dermatitis	18	442	426
Atopic Dermatitis	24	460	426
Psoriasis	36	1,699	1,510
Neurodermatitis	18	351	324
Total	144	4,174	3,808

*Complete bibliography on request.

†Expressed by the authors as excellent, very good, good, complete remission of inflammation, etc.

PRESCRIBING INFORMATION

For initiation of therapy: Cream 0.025%, 5 and 15 Gm. tubes, 425 Gm. jars; *for emollient effect:* Ointment 0.025%, 15 Gm. tubes; *for maintenance therapy:* Cream 0.01%, 15 and 45 Gm. tubes, 120 Gm. jars; *for intertriginous or hairy sites:* Solution 0.01%, 20 cc. and 60 cc. plastic squeeze bottles; *for infected inflammatory dermatoses:* Neo-Synalar® Cream (0.025% fluocinolone acetonide, neomycin sulfate, equivalent to 0.35% neomycin base), 5 and 15 Gm. tubes.

CONTRAINDICATIONS: Tuberculous, fungal, and most viral lesions of the skin, (including herpes simplex, vaccinia, and varicella). Not for ophthalmic use. Contraindicated in individuals with a history of hypersensitivity to any of the components. PRECAUTIONS: Synalar preparations are virtually nonsensitizing and nonirritating. However, the solution may produce burning or stinging when applied to denuded or fissured areas. In some patients with dry lesions, the solution may increase dryness, scaling or itching. While topical steroids have not been reported to have an adverse effect on pregnancy, the safety of their use on pregnant females has not absolutely been established. Therefore, they should not be used extensively on pregnant patients, in large amounts, or for prolonged periods of time. Prolonged use of any antibiotic may result in overgrowth of nonsusceptible organisms; if this occurs, appropriate therapy should be instituted. When severe local infection or systemic infection exists, the use of systemic antibiotics should be considered, based on susceptibility testing. SIDE EFFECTS: Side effects are not ordinarily encountered with topically applied corticosteroids. As with all drugs, however, a few patients may react unfavorably to Synalar under certain conditions. The neomycin in Neo-Synalar Cream rarely produces allergic reactions.

REFERENCES: 1. Lerner, L. J., Bianchi, A., Turkheimer, A. R., Singer, F. M., and Borman, A.: Anti-inflammatory steroids: potency, duration and modification of activities. Ann NY Acad Sci 116:1071 (Aug. 27) 1964. 2. Idem: Comparison of anti-granuloma, thymolytic and glucocorticoid activities of anti-inflammatory steroids. Proc Soc Exp Biol Med 116:385 (June) 1964. 3. Ringler, A.: Activities of adrenocorticosteroids in experimental animals and man, in Dorfman, R. I.: Methods of hormone research, New York, Academic Press, 1964. vol. III. pp. 234-280. 4. Gubersky, V. R.: To be published.

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BOOKSHELF

New books received are acknowledged in this section. From these books, selections will be made for reviews in the interest of the readers and as space permits, Reviews are written by members of the faculty of the University of Wisconsin Medical School. Books here listed will be available on loan from the Medical Library Service, S.M.I. Building, North Charter Street, Madison, Wisconsin 53706

BOOKS RECEIVED

ENRICO BOTTINI AND JOSEPH LISTER IN THE METHOD OF ANTISEPSIS

(Pioneers of Antiseptic Era), G. P. Arcieri, M.D., Professor of History of Medicine, Universities and Superior Institutes of Italy. Published by Alcmaeon Editions Co., 2421 Webb Avenue, New York, N. Y., 10468. 29 pages. Price: $3.00.

ETHICS IN MEDICAL PROGRESS

(Ciba Foundation Symposium) Edited by G. E. W. Wolstenholme and Maeve O'Connor. Published by Little, Brown and Company, Boston, 1966. This book has made special reference transplantation and will interest all those concerned with the nature of our society today. The reader clearly sees how medical problems are often affected by the views of people in general and by the historical attitudes embodied in the law. 257 pages. Price: $11.75.

PRINCIPLES OF BIOMOLECULAR ORGANIZATION

(Ciba Foundation Symposium) Edited by G. E. W. Wolstenholme and Maeve O'Connor. Published by Little, Brown and Company, Boston, 1966. Design principles in organized biomolecular structures are the basis of this international symposium. The symposium deals with the anatomical, molecular, and crystal structure of organs. Anatomists, biochemists, physiologists, virologists, and anyone intersted in cellular biology at an advanced level will find the discussion of particles, fibres, membranes, and solid crystal bodies an essential reference in this field. 491 pages. Price: $15.00.

DOCUMENTARY HISTORY OF PSYCHIATRY

Edited by Charles E. Goshen, M.D. Published by Philosophical Library, 15 E. 40th Street, New York, N. Y. The basic writing of outstanding psychiatrists and clinical psychologist, from the days of Hippocrates to Sigmund Freud. Some of the essays were translated from the original Greek, Latin, French and German. Doctor Goshen was formerly Research Director of the American Psychiatric Association, Washington. He is also Fellow of the American Psychiatric Association. 904 pages. Price: $20.00.

RADIOLOGY IN WORLD WAR II

Office of the Surgeon General, Department of the Army, Washington, D. C., 1966, prepared and published under the direction of Lt. General Leonard D. Heaton, The Surgeon General, United States Army. Edited by Dr. Kenneth D. A. Allen (formerly Col, MC). Explains in detail the development of the routine diagnostic use of x-ray under field conditions in disease and in combat and noncombat trauma. It relates the advances in radiation therapy, including the splendid work with supervoltage therapy developed at Walter Reed General Hospital during the war and so profitably expanded since. It unfolds the radiologic story of the Manhattan Project, the top secret World War II project which developed the atomic bomb, as told by its chief medical officer, Dr. Stafford L. Warren. Its 37 chapters were written by 31 contributors, has 1132 pages, 317 illustrations, 8 charts, 14 maps, and 14 tables. Price: $8.25. Superintendent of Documents, U. S. Government Printing Office, Washington, D. C. 20402.

MODERN TREATMENT Vol. 4, #1

Published bi-monthly by Hoeber Medical Division, Harper & Row, Publ. Inc. $16.00 per year by subscription. Treatment of Complications of Diabetes —Guest Editor, Charles R. Shuman, M.D. and Treatment of Pericardial Diseases—Guest Editor —Felic M. Cortes, M.D., M.S. (Med.).

REPORT OF THE SCIENTIFIC DIRECTOR

From The Council for Tobacco Research—U.S.A. Annual Report of the Scientific Director, Clarence Cook Little, Sc.D.—Tobacco—Health Studies, reviewed in Annual Report. 78 pages.

COMPREHENSIVE CARE SERVICES IN YOUR COMMUNITY

U.S. Department of Health, Education, and Welfare. Public Health Service Publication No. 1353, Sept. 1966. Superintendent of Documents, U. S. Government Printing Office, Washington, D. C. 20402. 54 pages. Price: 25¢.

THE UNIVERSITY OF WISCONSIN MEDICAL SCHOOL —A Chronicle, 1848–1948

By Paul F. Clark, emeritus professor of Medical Microbiology, published for The Wisconsin Medical Alumni Assoc. by the University of Wisconsin Press, Madison, London, and Milwaukee, Box 1379, Madison, Wisconsin 53701. 269 pages. Price: $10.00.

ABORTION AND THE LAW

Edited by David T. Smith, Assoc. Prof. of Law, Western Reserve University, Cleveland, Ohio, 44106. It is the purpose of ABORTION AND THE LAW to contribute to the scrutiny by examining the question of abortion, both criminal and therapeutic, in a number of contexts. The principal focus of the book is legal, but because it is impossible to discuss abortion at all without giving some consideration to its ethical and medical aspects, the essays study these as well. This is a frank book, because abortion is not a topic one can discuss without developing a position of ones own. 237 pages. Price: $7.00.

EGG IMPLANTATION

Ciba Foundation Study Group No. 23. Edited by G. E. W. Wolstenholme and Maeve O'Connor. Little, Brown and Co., Boston. 1966. 112 pages. Price: $3.50.

HISTONES—THEIR ROLE IN THE TRANSFER OF GENETIC INFORMATION

Ciba Foundation Study Group No. 24. Edited by A. V. S. de Reuck and Julie Knight. Little, Brown and Co., Boston. 1966. 115 pages. Price: $3.50.

THE THYMUS

Experimental and clinical studies. Ciba Foundation Symposium. Edited by G. E. W. Wolstenholme and Ruth Porter. Little, Brown and Co., Boston 1966. 538 pages. Price: $15.

REPORT OF THE HEALTH ADVISORY COMMITTEE TO THE APPALACHIAN REGIONAL COMMISSION

Community planning, comprehensive services. March 1966. 364 pages.

PATIENTS DISCHARGED FROM SHORT-STAY HOSPITALS

United States—October–December 1964. Vital and Health Statistics, data from the hospital discharge survey. National Center for Health Statistics, Series 13, No. 1. U.S. Department of Health, Education, and Welfare, Public Health Service, Washington, D.C. October 1966. 19 pages. Price: 25¢.

TOUCH, HEAT AND PAIN

Ciba Foundation Symposium. Edited by A. V. S. de Reuck and Julie Knight. Little, Brown and Co., Boston. 1966. 389 pages. Price: $14.

METHODS AND RESPONSE CHARACTERISTICS

National Natality Survey, United States, 1963. Vital and Health Statistics, data from the National Vital Statistics System. National Center for Health Statistics, Series 22, No. 3. U.S. Department of Health, Education, and Welfare, Public Health Service. September 1966. 36 pages. Price: 30¢.

REPORT OF THE UNITED STATES DELEGATION TO THE INTERNATIONAL CONFERENCE FOR THE EIGHTH REVISION OF THE INTERNATIONAL CLASSIFICATION OF DISEASES

Geneva, Switzerland—July 6–12, 1965. Vital and Health Statistics, Documents and Committee Reports. National Center for Health Statistics, Series 4, No. 6. U.S. Department of Health, Education, and Welfare, Public Health Service. September 1966. 74 pages. Price: 50¢.

HEALTH RESOURCES STATISTICS, 1965

By U. S. Department of Health, Education, & Welfare, Public Health Service National Center for Health Statistics—First edition contains Health Manpower, 1965 and presents data on the numbers of health personnel employed and their location by State; growth in employment since 1950; distribution by type of practice, function, and/or specialty; trends in numbers of training programs and graduates since 1950; and the location of institutions that now offer training programs, with student enrollments and graduates in the academic year 1964–65. 182 pages. Price: $1.25.

NO LAUGHING MATTER

U. S. Department of Health, Education, and Welfare, publication contains 60 cartoons on Air Pollution. 60 pages. Price: $.70.

BOOK REVIEWS

FOUNDATIONS OF ANESTHESIOLOGY

By Albert Faulconer, Jr., M.D. and Thomas E. Kyes, A.B., M.A., Charles C. Thomas, Publisher, Springfield, Ill. 1965. 1337 pages. Price: $38.50.

This monumental work truly lives up to its title, FOUNDATIONS OF ANESTHESIOLOGY. The authors have included both from the English and translations from other languages a vast amount of material, and put it into an orderly "Autobiography of Anesthesiology," as they state in their Preface I believe they have certainly accomplished their purpose.

The book is organized so completely that it can be used as an encyclopedia of anesthesia literature. It is a marvelous reference book, both for a neophyte and for the professor and scholar. Each person whose work is reproduced in these two volumes has a biographical sketch preceding his classic contribution to the development of Anesthesiology as a science. These biographical sketches alone are invaluable. The accurate reproduction of the classical and historical articles makes it easy for the student at any level to be able to read and have at his finger tips material which would take him months and years to dig out of various scattered libraries.

This book is a "must" for any teaching department library and Medical School Library. This book is also an extremely enjoyable book to read for anyone having the slightest interest in the history and development of the science of Anesthesiology.

The book is beautifully printed and illustrations are more than adequate. It is organized perfectly, and I have thoroughly enjoyed reviewing it and reading it.—KARL L. SIEBECKER, M.D.

CARDIAC EVALUATION IN NORMAL INFANTS

By Robert F. Ziegler, M.D., C. V. Mosby Co., St. Louis. 1965. 170 pages. Price: $12.75.

This book is written in a prose style which is extraordinarily cumbersome and difficult to follow. There are at least a half dozen parenthetical phrases on each page. In addition to the problem of following the vagaries of style, much of the physiological reasoning is murky and confused. The majority of the illustrations in this book are electrocardiograms, but the reproductions are poor and it is sometimes impossible to see where a specific deflection terminates.

There have been other publications during the past few years describing the changing concepts of pathophysiology of the circulatory system in the infant age group. Most of these other publications would be preferable to this book.—JAY M. LEVY, M.D.

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IN BRIEF.

Contraindications: History of previous hypersensitivity to oxazepam. Oxazepam is not indicated in psychoses.

Precautions: Hypotensive reactions are rare, but use with caution where complications could ensue from a fall in blood pressure, especially in the elderly. Withdrawal symptoms upon discontinuation have been noted in some patients exhibiting drug dependence through chronic overdose. Carefully supervise dose and amounts prescribed, especially for patients prone to overdose; excessive, prolonged use in susceptible patients (alcoholics, ex-addicts, etc.) may result in dependence or habituation. Reduce dosage gradually after prolonged excessive dosage to avoid possible epileptiform seizures. Withdrawal symptoms following abrupt discontinuance are similar to those seen with barbiturates. Caution patients against driving or operating machinery until absence of drowsiness or dizziness is ascertained. Warn patients of possible reduction in alcohol tolerance. Safety for use in pregnancy has not been established.

Not indicated in children under 6 years; absolute dosage for 6- to 12-year-olds not established.

Side Effects: Therapy-interrupting side effects are rare. Transient mild drowsiness is common initially; if persistent, reduce dosage. Dizziness, vertigo and headache have also occurred infrequently; syncope, rarely. Mild paradoxical reactions (excitement, stimulation of affect) are reported in psychiatric patients. Minor diffuse rashes (morbilliform, urticarial and maculopapular) are rare. Nausea, lethargy, edema, slurred speech, tremor and altered libido are rare and generally controllable by dosage reduction. Although rare, leucopenia and hepatic dysfunction including jaundice have been reported during therapy. Periodic blood counts and liver function tests are advised. Ataxia, reported rarely, does not appear related to dose or age. These side reactions, noted with related compounds, are not yet reported: paradoxical excitation with severe rage reactions, hallucinations, menstrual irregularities, change in EEG pattern, blood dyscrasias (including agranulocytosis), blurred vision, diplopia, incontinence, stupor, disorientation, fever and euphoria.

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Recent Wisconsin Licentiates

The following physicians were granted licenses by oral examination by the State Board of Medical Examiners at a meeting in Madison, January 11, 1967.

Name	*School of Graduation*	*Year*	*City*
Auer, George G.	University of Iowa	1953	Guttenberg, Ia.
Auger, Armand J.	Laval University	1962	Milwaukee
Brooks, Kenneth H.	Indiana University	1962	Kenosha
Burrill, Raymond E.	Loyola University	1961	Marshfield
Cook, Colin B.	Middlesex Hospital	1951	Winnebago
Cukrowski, Walter S., II	Marquette University	1965	Satellite Beach, Fla.
Grossman, Marvin	Jefferson Medical College	1961	Great Lakes, Ill.
Howe, Gertrude E.	University of Illinois	1941	Middleton
Jaramillo, Carlos A.	University of San Marcos	1950	Monroe
Kamper, David G.	Harvard Medical School	1960	Cincinnati, Ohio
Kennedy, Kevin S.	Marquette University	1966	Milwaukee
Kijner, Herry H.	National University	1955	Milwaukee
Lagus, Arne T.	University of Minnesota	1965	St. Croix Falls
Litton, Linda T.	University of New York	1962	Milwaukee
Lukaszek, Henry J.	University of Poznan	1937	Monroe
Menco, Hans S.	University of Amsterdam	1956	Manchester, Conn.
Messenger, Michael A.	University of Illinois	1963	Madison
Mills, John M.	University of Illinois	1959	Westchester, Ill.
Najafzadeh, Moktar	University of Lyon, France	1933	Sparta
Neubecker, Mary S.	University of Texas	1947	Oshkosh
Nichols, Frank E.	Northwestern University	1964	Chicago, Ill.
Nigro, Henry	Boston University	1929	Winnebago
Patterson, Alan E.	Ohio State University	1963	Milwaukee
Peterson, Donald H.	University of Minnesota	1940	St. Paul, Minn.
Ryan, Allen J.	Creighton University	1941	Madison
Saculla, Francois J.	Montpellier College	1964	Racine
Sealby, Robert L.	University of Michigan	1963	Shawano
Spence, Clarence	Howard University	1966	Milwaukee
Stewart, Richard D.	University of Michigan	1955	Brookfield
Yasatan, Nasip H.	University of Istanbul	1953	Wood

The following physicians were granted licenses by oral examination by the State Board of Medical Examiners at a meeting in Madison, April 21, 1967.

Anderson, Gay R.	Northwestern University	1964	Forest Park, Ill.
Atkins, Frances E.	Washington University	1965	Madison
Berry, A. Erwin	University of Arkansas	1935	Oelwein, Ia.
Bess, Samuel H.	Chicago Medical School	1940	Freeport, Ill.
Biedlingmaier, Gerard J.	Jefferson Medical College	1954	Grand Blanc, Mich.
Blodgett, Frederic M.	Yale University	1945	Milwaukee
Cummins, George M., Jr.	University of Chicago	1941	Chicago, Ill.
Dickson, Kenneth B.	University of Toronto	1955	Marshfield
Harrington, Avery R.	University of Pennsylvania	1956	Orange, Conn.
Hebble, William M.	University of Illinois	1960	Indianapolis, Ind.
Kadin, Marshall E.	Northwestern University	1965	Milwaukee
Kinde, Robert R.	University of Michigan	1962	Appleton
Kochell, Richard L.	Indiana University	1962	Janesville
Langsjoen, Ralph J.	University of Minnesota	1958	Champaign, Ill.
Leibowitz, Morton M.	New York University	1965	Milwaukee
McGloin, John J.	Loyola University	1957	Neenah
McGloin, Mary T.	Loyola University	1957	Neenah
McMillan, Willis G.	University of Manitoba	1962	Madison
Mendez-Beauchamp, Victor	University of Madrid	1962	Milwaukee
Patton, Charles H.	University of Illinois	1959	Ann Arbor, Mich.
Rud, James A.	University of Nebraska	1959	Sioux Falls, S.D.
Sooknandan, Ghonsham	National University of Mexico	1964	Chicago, Ill.
Ritzenthaler, David O.	University of Wisconsin	1964	Beaver Dam
Toohill, Robert J.	Marquette University	1960	Milwaukee
Wieclawek, Tadeusz	Bologna University	1948	Dixon, Ill.
Winterhalter, Joseph	Northwestern University	1960	Davis, Ill.
Zellmer, James H.	Marquette University	1964	Scotia, N.Y.

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Term Expires 1968

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Fourth District:
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Sixth District:
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S. W. Hollenbeck.....Milwaukee

Thirteenth District:
Marvin Wright.....Rhinelander

Term Expires 1968

F. E. Drew.....Milwaukee
(Past President)

Delegates to American Medical Association
(Terms end on December 31 of year indicated)

John M. Bell, Marinette, 1968
J. C. Fox, La Crosse, 1968
E. L. Bernhart, Milwaukee, 1968
R. E. Galasinski, Milwaukee, 1967
W. B. Hildebrand, Menasha, 1967
N. A. Hill, Madison, 1967

Alternates

C. J. Picard, Superior, 1968
George Collentine, Jr., Milwaukee, 1967

List of Officers and Scheduled Meetings of County Medical Societies

COUNTY	PRESIDENT	SECRETARY	MEETING DATE
Ashland–Bayfield–Iron	J. M. Janquet 220 7th Ave. W., Ashland	C. A. Grand Masonic Temple Bldg., Ashland	
Barron–Washburn–Sawyer–Burnett	R. M. Anderson Cumberland	D. G. MacMillan 1220 E. Woodland, Barron	Second Tuesday 7:30 p.m.
Brown	Francis B. Vande Loo Wrightstown	K. C. Mickle 3319 Delahaut Green Bay	Second Thursday*
Calumet	John A. Knauf Stockbridge	J. C. Pinney Hilbert	
Chippewa	Robert Mathwig Stanley	Frank B. Sazama 133 W. Central St. Chippewa Falls	Second Tuesday
Clark	J. W. Koch Colby	Bahri Gungor Neillsville	
Columbia–Marquette–Adams	Thomas S. Westcott 115 W. Chestnut Pardeeville	Fredrick H. Bronson 310 W. Conant St. Portage	Every Third Month 7:00 p.m.
Crawford	James R. Wong 229 S. Michigan St. Prairie du Chien	H. L. Shapiro Prairie du Chien	Third Wednesday
Dane	C. K. Kincaid City–County Bldg. Room 507, Madison	E. L. Belknap, Jr. 20 S. Park St. Madison	Second Tuesday**
Dodge	Richard W. Way 209 S. Univ. Ave. Beaver Dam	Richard A. Damon P.O. Box 512, Beaver Dam	Last Thursday*
Door–Kewaunee	Nicholas R. Wagener 802 North 3rd Ave. Sturgeon Bay	Reynold M. Nesemann 213 Ellis St. Kewaunee	
Douglas	Enzo Krahl 3600 Tower Ave., Superior	Robert Sellers 318 21st Ave. E., Superior	First Wednesday* Hotel Superior
Eau Claire–Dunn–Pepin	William T. Mautz 204 E. Grand Ave. Eau Claire	Lou A. Raymond 605 Walker Ave. Eau Claire	Last Monday
Fond du Lac	Russell S. Pelton 416 Watson St. Ripon	John G. Parrish, Jr. 1921 Mulen Drive Fond du Lac	Fourth Thursday*
Forest	E. F. Castaldo Laona	D. V. Moffet, Crandon	
Grant	Paul K. Edwards Bloomington	H. W. Carey 257 Madison St., Lancaster	Last Thursday, March, June, Sept. and Nov.
Green	Leslie G. Kindschi 1770 13th St. Monroe	James H. Weeks 921 16th Ave., Monroe	
Green Lake–Waushara	Steve R. Osicka 147 N. State St., Berlin	Erich M. Schmidt P. O. Box 48, Berlin	Last Thursday, every other month starting in Jan.

* Except June, July and August. ** Except July and August.

List of Officers and Scheduled Meetings of County Medical Societies (Continued)

COUNTY	PRESIDENT	SECRETARY	MEETING DATE
Iowa	David R. Downs Dodgeville	H. P. Breier Montfort	Second Tuesday
Jefferson	Robert G. Handeyside 210 Madison Ave. Fort Atkinson	Stanley Vognar 210 Madison Ave., Ft. Atkinson	Third Thursday*
Juneau	J. H. Vedner Mauston	Jack Strong Mauston	Second Tuesday Hess Clinic in Mauston
Kenosha	Walter C. Rattan 6530 Sheridan Rd. Kenosha	Fredrick Wood, Jr. 6530 Sheridan Rd. Kenosha	First Thursday* Elks Club
La Crosse	Wm. B. Gallagher 312 State St. La Crosse	Gunnar A. Gundersen, Jr. 1836 South Ave. La Crosse	Third Monday
Lafayette	N. A. McGreane 112 E. Ann St. Darlington	L. L. Olson 504 Wells St., Darlington	Last Tuesday
Langlade	John E. Garritty Antigo	Donald V. Blink 837 Clermont, Antigo	First Monday
Lincoln	James F. Bigalow 712 E. 2nd St., Merrill	James S. Janowiak 716 E. 2nd St., Merrill	
Manitowoo	T. H. Rees 104 North 8th St. Manitowoc	M. A. Jacobi 2300 Western Ave. Manitowoc	Last Thursday
Marathon	Gregory J. Bachhuber 614—3rd Ave. Wausau	Gordon L. Backer 630 First St., Wausau	
Marinette–Florence	J. D. Zeratsky 1510 Main St., Marinette	K. G. Pinegar 516 Houston, Marinette	Third Wednesday St. Joseph's Hospital
Milwaukee	Christopher, R. Dix 2040 W. Wisconsin Ave. Milwaukee	William L. Coffey, Jr. 536 W. Wisconsin Ave. Milwaukee Mr. J. O. Kelley, Ex. Sec. 756 N. Milwaukee, Milw.	Second Thursday
Monroe	Dewitt Beebe Sparta	E. O. Lukasek 110 E. Franklin St.,, Sparta	Third Monday
Oconto	F. W. Klutzow Main St., Gillett	Kenneth L. Strehe 134 N. Main St., Oconto Falls	
Oneida–Vilas	I. Nik Nevin 134 N. Oneida Ave. Rhinelander	Marvin Wright 1020 Kahel Ave., Rhinelander	Monthly
Outagamie	James E. Gmeiner 1260 Valley Rd., Appleton	G. J. Petersen 506 E. Longview Dr. Appleton	Third Thursday* Elks Club
Ozaukee	George F. Savage 125 N. Franklin Port Washington	Philip W. Wallestad 309 E. Norport Dr. Port Washington	
Pierce–St. Croix	F. B. Klaas East Ellsworth	C. A. Olson Baldwin	Third Tuesday
Polk	Jack R. Inyart Osceola	D. F. Schwah Frederic	Third Thursday 7:00 p.m.
Portage	J. A. Litzow 405½ Main St. Stevens Point	J. F. Riordan 2501 Main St. Stevens Point	
Price–Taylor	G. L. Thomas P.O. Box 218, Prentice	Walther W. Meyer 410 S. Second, Medford	Last Saturday, Feb., May, Aug., and Nov.
Racine	William J. Madden 1841 Wisconsin Ave. Racine	Elizabeth A. Steffen 734 Lake St. Racine Mr. G. N. Geraghty 600 Villa Street, Racine Exec. Sec.	Third Thursday
Richland	Roy C. Glise 890 East Kinder St. Richland Center	L. M. Pippin 1313 W. Seminary St. Richland Center	First Thursday Richland Hospital
Rock	John L. Babb 2422 Riverside Dr., Beloit	William A. Pruett 2031 Riverside Dr., Beloit	Fourth Tuesday
Rusk	Joseph E. Murphy 403 East Miner Ave. Ladysmith	Wm. B. A. J. Bauer Ladysmith	First Tuesday
Sauk	Robert G. Hansel 407 Oak Street Barahoo	John T. Siebert 101 Fourth St. Barahoo	Second Tuesday*
Shawano	Donald W. Schulz 139 S. Main St., Shawano	A. J. Sebesta P. O. Box 311, Shawano	Third Wednesday
Sheboygan	Burnell F. Eckardt 1226 North Eighth St. Sheboygan	Robert A. Keller 718 South 27th St. Sheboygan	First Thursday
Trempealeau–Jackson–Buffalo	Charles F. Meyer Box 180 Independence	Eugene Krohn 221 Main St. Black River Falls	Fourth Tuesday
Vernon	Thomas Boston 840 Water Ave., Hillsboro	T. Zimmermann 100 W. Melby St., Westby	Last Wednesday
Walworth	E. D. Hudson Rt. 3, Hwy. 50 East Lake Geneva	R. D. Peterson 100 S. Washington Elkhorn	Second Thursday*
Washington	W. E. Scheunemann 626 Cedar St. West Bend	R. F. Sorensen 633 14th Ave., West Bend	Fourth Thursday
Waukesha	J. R. Matt 915 Summit Ave. Oconomowoc	D. P. Nachazel, Jr. 102 E. Main St., Waukesha	First Wednesday
Waupaca	Harry S. Caskey Clintonville	Joseph W. Weber 322 N. Water St. New London	
Winnebago	Frederick H. Smith 116 S Commercial St., Neenah	Richard C. Wolfgram 2121 Bowen St., Oshkosh	First Thursday
Wood	J. L. Burns, Jr. 630 S. Central, Marshfield	J. J. Mulvaney 630 S. Central, Marshfield	Four times a year

* Except June, July and August.

MEDICAL MEETINGS

POSTGRADUATE COURSES

1967 WISCONSIN

Oct. 4: Workshop in Speech-Making, sponsored by Milwaukee County Heart Committee in cooperation with the Speech Communication Center, Wisconsin State University–Milwaukee, at the new Central YMCA, Milwaukee.

Oct. 4–6: Annual meeting, Wisconsin Nurses Association, Milwaukee.

Oct. 9–20: Advanced Maternity Program in Delivery Room Nursing for graduate nurses, Marquette University College of Nursing, Milwaukee

Oct. 10–12: Annual meeting, Wisconsin Division of American Cancer Society, Oshkosh.

Oct. 13: Industrial Health Clinic, sponsored by the State Medical Society of Wisconsin, Employers Mutuals new building complex, Wausau.

Oct. 16–20: Wisconsin Work Week of Health, State Medical Society of Wisconsin, Madison.

Oct. 16–21: Postgraduate course, "Basic and Clinical Aspects of Therapy in Advanced Cancer," University of Wisconsin Medical Center, Madison.

Oct. 20: Annual meeting, Wisconsin Orthopedic Society, Wingspread, Racine.

Oct. 21: Annual fall cancer conference (The Cancer Scrimmage), University of Wisconsin Medical Center, Madison.

Nov. 1–2: Wisconsin Heart Association course in "Clinical Cardiology," at Holiday Inn No. 2, Madison.

Nov. 2–3: Conferences in Geriatric and Psychiatric Nursing, University Extension, Madison.

Nov. 4: Seminar on "The Doctor's Assistant Tomorrow," Marshfield Clinic Foundation, St. Joseph's Hospital, Marshfield.

Nov. 6–17: Advanced Maternity Program in Delivery Room Nursing for graduate nurses, Marquette University College of Nursing, Milwaukee.

Nov. 7: Dearholt Lecture, UW, Madison.

Nov. 8: Dearholt Lecture, Marquette, Milwaukee County General Hospital, Milwaukee.

Nov. 8–9: Wisconsin Welfare Council conference, Pfister Hotel, Milwaukee.

Nov. 9: Conference for Nursing Home Nurses, University Extension, Milwaukee.

Nov. 9–10: Milwaukee Medical Conference, sponsored by The Medical Society of Milwaukee County, County Hospital, Milwaukee.

Nov. 10: Conference for Nursing Home Nurses, University Extension, Wausau.

Nov. 10–12: Fall meeting, Wisconsin Society of Pathologists (jointly with Wisconsin Association of Medical Technologists), Milwaukee.

Nov. 13–14: Quackery conference, sponsored by State Medical Society of Wisconsin, Milwaukee Auditorium.

Nov. 16: State School Health Council, Wisconsin Center, Madison.

Nov. 17: Medical-Legal-Industrial Symposium on "Pulmonary Diseases in Industry," sponsored by Mount Sinai Hospital, at Pfister Hotel, Milwaukee.

Dec. 6: UW "In-Depth" postgraduate teaching program, Madison.

1968 WISCONSIN

Jan. 15–26: Advanced Maternity Program in Delivery Room Nursing for graduate nurses, Marquette University College of Nursing, Milwaukee.

Jan. 18: UW "In-Depth" postgraduate teaching program, Madison.
Chicago

Feb. 7–8: "Modern Separation Methods of Macromolecules and Particles," University of Wisconsin, Madison.

Feb. 12–23: Advanced Maternity Program in Delivery Room Nursing for graduate nurses, Marquette University College of Nursing, Milwaukee.

Feb. 21: UW "In-Depth" postgraduate teaching program, Madison.

Mar. 4: Postgraduate course, "Hypoglycemias in Infants and Children," sponsored by Marquette University at Children's Hospital, Milwaukee.

Mar. 11: Postgraduate course, "Etiology and Management of Nephrosis in Children," sponsored by Marquette University at Children's Hospital, Milwaukee.

Mar. 11–22: Advanced Maternity Program in Delivery Room Nursing for graduate nurses, Marquette University College of Nursing, Milwaukee.

Mar. 18: Postgraduate course, "Prevention of Mental Retardation," sponsored by Marquette University at Children's Hospital, Milwaukee.

Mar. 21: UW "In-Depth" postgraduate teaching program, Madison.

Mar. 25: Postgraduate course, "Emotional Crises Among Adolescents," sponsored by Marquette University, Milwaukee.

Mar. 27–28: Sports Medicine and General Medicine, University of Wisconsin, Madison.

Apr. 4–5: Wisconsin Anti-Tuberculosis annual meeting, Milwaukee.

Apr. 4–6: Fetus and Newborn, University of Wisconsin, Madison.

Apr. 18–19: Conference for Directors of Nursing in Small Hospitals, University Extension, Marshfield.

Apr. 22–May 3: Advanced Maternity Program in Delivery Room Nursing for graduate nurses, Marquette University College of Nursing, Milwaukee.

May 9–10: Conference for Directors of Nursing in Small Hospitals, University Extension, Madison.

May 14–16: Annual meeting, State Medical Society of Wisconsin, Milwaukee.

June 8: Semi-annual meeting, Wisconsin Society of Pathologists, University Hospitals, Madison.

1967 NEIGHBORING STATES

Oct. 2–6: Annual clinical congress, American College of Surgeons, Chicago.

Oct. 4–5: Annual Midwest Interprofessional Seminar on Diseases Common to Animals and Man, University of Missouri, Columbia.

Oct. 11: Third Annual Kidney Disease Symposium, Sheraton–Chicago Hotel, Chicago.

Oct. 12–13: Head and Neck Radiology Conference, Department of Radiology, College of Medicine of the University of Illinois, Chicago.

Oct. 14–20: Annual Otolaryngologic Assembly, at Illinois Eye and Ear Infirmary, Medical Center, Chicago.

Oct. 11: "Frontiers of Medicine" series—Diabetes Mellitus and Common Gynecological Problems, The University of Chicago Hospitals and Clinics, Chicago.

Nov. 6–8: First of two identical sessions—Clinical Reviews, Mayo Clinic and Foundation, Rochester, Minn.

Nov. 6–9: Annual scientific assembly, Interstate Postgraduate Medical Association, Palmer House, Chicago

Nov. 8: "Frontiers in Medicine" series—Clinical Allergy and Immunology, The University of Chicago Hospitals and Clinics, Chicago.

Nov. 13–15: Second of two identical sessions—Clinical Reviews, Mayo Clinic and Foundation, Rochester, Minn.

Dec. 13: "Frontiers in Medicine" series—Shock, The University of Chicago Hospitals and Clinics, Chicago

1968 NEIGHBORING STATES

Jan. 19–20: Course in "New Concepts in Problems of Completed Stroke," Kenny Rehabilitation Institute, Minneapolis Minn.

Mar. 7–8: Institute of Medicine of Chicago Workshop —The Doctor and His Hospital, Pick-Congress Hotel.

1967 OTHERS

Oct. 21–26: Annual Meeting, American Academy of Pediatrics, Washington, D. C.

Oct. 23–27: American Public Health Association, Hotel Fontainebleau, Miami Beach, Fla.

November: Association of State and Territorial Health Officers, Washington, D. C.

Nov. 16–19: Annual convention, National Society for Crippled Children and Adults, Century Plaza Hotel, Los Angeles, Calif.

Nov. 25–26: American College of Chest Physicians Interim Clinical Meeting, Warwick Hotel, Houston, Tex.

Nov. 26: Ninth national conference on the medical aspects of sports, in conjunction with the annual clinical convention of the American Medical Association, Nov. 26–29, Houston, Tex.

1968 OTHERS

Jan. 10–12: Program on "Current Concepts in Cardiology," Institute for Cardiovascular Diseases, Good Samaritan Hospital, Phoenix, Ariz.

Jan. 14–18: Second annual meeting of the Society of Cryo-Ophthalmology, Miami Beach, Fla.

Feb. 5–7: Aspen Conference on the Newborn at the Aspen Institute for Humanistic Studies, Children's Hospital, Denver, Colo.

Feb. 19–21: First of three 1968 sectional meetings in Dallas, Tex., of the American College of Surgeons.

May 4–9: Annual teaching seminar, International Academy of Proctology, Montreux–Palace Hotel, Montreux, Switzerland.

Sept. 18–20: Sixth National Cancer Conference, Denver Hilton Hotel, Colo.

Oct. 21–25: Annual Clinical Congress, American College of Surgeons, Atlantic City, N.J.

1967 AMA

Nov. 26–29: Clinical convention, Astro Hall of Astrodome complex and Shamrock–Hilton Hotel, Houston, Tex.

For listing of other meetings see the JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION.

UW Course: Therapy of Advanced Cancer

The Division of Clinical Oncology of the University of Wisconsin Medical Center is presenting a postgraduate course on "Basic and Clinical Aspects of Therapy in Advanced Cancer" at University Hospitals, Oct. 16–20. The course will be followed by the annual Cancer Scrimmage on Oct. 21.

The University faculty participating includes: F. J. Ansfield, M.D.; F. H. Bach, M.D.; R. R. Brown, Ph.D.; G. T. Bryan, M.D., Ph.D.; A. R. Curreri, M.D.; H. L. Davis, Jr., M.D.; F. F. Gollin, M.D.; Charles Heidelberger, Ph.D.; R. O. Johnson, M.D.; W. A. Kiskin, M.D.,; B. C. Korbitz, M.D.; Sanford Mackman, M.D.; Guillermo Ramirez, M.D.; R. J. Samp, M.D.; H. M. Temin, Ph.D.; Halvor Vermund, M.D., Ph.D.; and W. H. Wolberg, M.D.

Registration fee is $100. Registration may be made with R. J. Samp, M.D., University Hospitals, Madison.

UW Fall Cancer Conference

The 13th Annual Fall Cancer Conference at the University of Wisconsin Medical Center will be on Saturday, Oct. 21, beginning at 9 a.m. The University of Wisconsin Division of Clinical Oncology sponsors the meeting jointly with the American Cancer Society, Wisconsin Division.

From 9 a.m. to 11:15 a.m. a variety of tumor papers and reports will be given representing many fields of cancer study. At 11:15 a.m. a special panel of top cancer research experts from several major areas of the School will discuss on-going research and answer audience questions relative to clinical and basic science matters.

The general theme is "What's Going On in Cancer," and the topics have been selected with Wisconsin physicians in mind.

Luncheon and the Wisconsin–Iowa football game follow. Registration fee is $2.00 (checks made out to the American Cancer Society) and football tickets, limit 2 per doctor attending, are $5.00 (checks made out to the Wisconsin Athletic Ticket Office).

Further communications to: R. J. Samp, M.D., University Hospitals, Madison, Wis. 53706.

WHA Clinical Cardiology Course

The Wisconsin Heart Association is presenting a two-day course in Clinical Cardiology Nov. 1–2 at the Holiday Inn No. 2 located on Highway 18 near Highway I-94 in Madison. The program is aimed directly at the practicing physician; and although newer techniques in treatment will be discussed, much of the program will concern itself with a review of existing useful clinical signs and techniques.

Dr. Richard H. Wasserburger, chairman of the Physicians Education Committee of the Wisconsin Heart Association has indicated that although the faculty is limited in size, the program has sufficient scope so that it will be well worth the physician's time.

Major presentations include the following:

WEDNESDAY, NOV. 1 (morning): *The Normal Cardiovascular Silhouette on X-ray*, by Richard R. Logan, M.D.; Identification of the atrium, ventricles, and great vessels in PA, lateral, and oblique projections. Relationship of the cardiac silhouette to body habitus, structural deformities of the thorax, and AP and bedside film techniques.

The Abnormal Cardiovascular Silhouette on X-ray, by John H. Juhl, M.D.: The identification of isolated cardiac chamber and great vessel enlargement. Useful signs in the recognition of mitral aortic and pulmonic valvular disease.

The Use and Abuse of Diuretic Agents, by Robert O. Burns, M.D.: A brief review of normal renal function and a critical evaluation of diuretics, mercurials, thiazides, triamterene (Dyrenium), spironolactones (Aldactone), ethacrynic acid (Edecrin), and furosemide (Lasix).

WEDNESDAY, NOV. 1 (afternoon): *Use and Abuse of Cardiac Drugs—Digitalis*, by Richard H. Wasserburger, M.D., *Anti-arrhythmic Agents*, by John J. Brandabur, M.D., and *Vasopressors*, by Robert O. Burns, M.D.

Recognition and Treatment of Cardiac Arrhythmias, by Richard H. Wasserburger, M.D.: Useful electrocardiographic signs in the identification of the major cardiac arrhythmias and the specifics of treatment. (Atrial tachycardia, atrial flutter, atrial fibrillation, atrial tachycardia with A-V block, ventricular tachycardia, and ventricular fibrillation.)

Informal Roundtable Discussions: Interesting chest films and ECGs will be projected for group

analysis by Doctors Juhl, Richard R. Logan, Mischa J. Lustok, and Wasserburger. Doctor Brandabur will exhibit and discuss the use of intracardiac pacemakers. Doctor Burns will discuss practical renal problems, including the indications for acute and chronic dialysis.

THURSDAY, NOV. 2 (morning): *Electrocardiographic Identification of Acute Myocardial Ischemia*, by Richard H. Wasserburger, M.D.: Techniques, indications, and contraindications of exercise tolerance tests. Clinical significance of "acute ischemic episodes."

Roentgen Signs in Cardiopulmonary Disease States, by John H. Juhl, M.D.: Useful signs in the recognition of pulmonary emboli, acute pulmonary edema, "disappearing tumors" of the lung, pleural and pericardial effusions.

Clinical Evaluation and Treatment of Acute and Chronic Complete Heart Block, by John J. Brandabur, M.D.: Drug therapy and utilization of temporary and permanent cardiac pacemakers. Simplified technique of insertion of a temporary venous cardiac pacer.

THURSDAY, NOV. 2 (afternoon): *Electrocardiographic Identification of Acute Myocardial Infarction*, by Richard H. Wasserburger, M.D.: Useful ECG signs in the detection of anterior and posterior wall myocardial infarctions.

A Practical Look at the Treatment of "Medical Shock," by Robert O. Burns, M.D.: A simplified technique for bedside central venous pressure monitoring.

Registration fee of $15.00 includes luncheons, coffee breaks, an evening refreshment hour, and a printed teaching manual. Ten hours of prescribed credit will be allowed by the American Academy of General Practice.

Further information will be sent to Wisconsin physicians by direct mail prior to the meeting. Communications can be sent to: Wisconsin Heart Association, 205 West Highland Ave., Milwaukee 53203.

Workshop on Speech-Making, Milwaukee

The Speakers Bureau of the Milwaukee County Heart Committee in cooperation with the Speech Communication Center, Wisconsin State University–Milwaukee, will sponsor a one day workshop in speech-making on Wednesday, Oct. 4, at the New Central YMCA, 915 W. Wisconsin Ave., Milwaukee.

The workshop is open to members of the Speakers Bureau and other individuals who act as spokesmen for the Wisconsin Heart Association in order to bring to them the newest techniques in public speaking, the use of audio-visual aids and audience question and answer sessions. Registration will be limited to 60 participants.

The morning program will begin at 9:00 and consist of a series of lectures by faculty members of the UWM Speech Communication Center on the theme: "Speech Making—A Communicative Transaction."

Following lunch, supervised laboratory practice will be held. Individual performances by the participants will be evaluated and advised by the faculty members.

Registration can be made through Mrs. Virginia Goldberg, Wisconsin Heart Association, 205 W. Highland Ave., Milwaukee, Wis. 53203.

Mount Sinai Hospital, Milwaukee, Symposium

Mount Sinai Hospital, Milwaukee, is presenting its Sixth Annual Medical-Legal-Industrial Symposium on "Pulmonary Diseases in Industry," Friday, Nov. 17 at the Pfister Hotel. The program will begin at 8:45 A.M. and terminate at 4 P.M.

Speakers and subjects were printed in the August issue. Further communication to: Raymond L. Rice, M.D., Chairman, 1967 Symposium Committee, 948 North Twelfth St., Milwaukee, Wis. 53233.

Interstate Postgraduate Assembly

The Interstate Postgraduate Medical Association will present its 52nd annual scientific assembly Nov. 6–9 at the Palmer House in Chicago. An outstanding program, including color TV and evening entertainment, has been planned. Major subjects to be covered are: New Approaches to the Old Problem of Addiction, Rehabilitation of the Amputee, Surgical TV, Common Dermatologic Problems, Management of Burns, Fertility and Infertility, Pediatric Trauma, Neurologic Diagnosis, Anti-Cancer Drugs, Venous Thrombosis, The Lumbar Spine, and many more.

Wisconsin participants are: Drs. Edwin H. Ellison, Gordon L. Snider, and George A. Collentine, Jr., Milwaukee; and Drs. A. R. Curreri and Warner V. Slack, Madison.

The program is acceptable for 21 elective hours by the American Academy of General Practice. Only charge is $15 for four days. For a complete program and registration forms write: Alton Ochsner, M.D. or Roy T. Ragatz, at 333 North Randall Avenue, Madison, Wis. 53706.

Sixth National Cancer Conference

The Sixth National Cancer Conference, sponsored by the American Cancer Society and the National Cancer Institute, will be held at the Denver Hilton Hotel, Denver, Colo., Sept. 18–20, 1968.

For further information write: Roald N. Grant, M.D., Coordinator, Sixth National Cancer Conference, % American Cancer Society, 219 East 42nd Street, New York, N. Y. 10017.

All members of the medical and related professions, research investigators and medical students are invited to attend. There is no registration fee.

Current Concepts in Cardiology

An intensive program on *Current Concepts in Cardiology*, with special emphasis on coronary disease, indication and management of valvular replacement, diagnosis and management of cardiac arrhythmias, vector-cardiography and applied cardiovascular physiology.

This program is being offered by the Institute for Cardiovascular Diseases at Good Samaritan Hospital, 1033 East McDowell Road, Phoenix, Ariz. 85002, Jan. 10–12, 1968. The meetings will be held at Del Webb's Towne House in Phoenix, Ariz.

This is an official postgraduate course of the American College of Cardiology. For information about this program, write to Mr. William B. Nelligan, Executive Director for the American College of Cardiology, 9650 Rockville Pike, Washington, D. C., 20015.

Aspen Conference on the Newborn

Children's Hospital, Denver, will present the Aspen Conference on the Newborn at the Aspen Institute for Humanistic Studies on Feb. 5, 6, and 7, 1968.

Morning seminars and discussions will be led by Jerold F. Lucey, M.D., Professor of Pediatrics, Univiersity of Vermont; Thomas K. Oliver, Jr., M.D., Professor of Pediatrics, University of Washington; and Edward J. Quilligan, M.D., Professor and Chairman, Department of Obstetrics, Yale University. Afternoons will be open.

Registration fee is $40.00. Registration will be limited to insure an informal meeting.

For further information write: Aspen Conference on the Newborn, Children's Hospital, 19th Avenue at Downing, Denver, Colo. 80218.

Problems of Completed Stroke

An innovation in continuing education has been planned for the course on "New Concepts in Problems of Completed Stroke" which will be held Jan. 19–20, 1968, at the Kenny Rehabilitation Institute, Minneapolis, Minn.

Formal lectures have been abandoned and instead the participant in the course is placed in as near the ideal learning situation as is feasible—at the patient's bedside. Emphasis is on active participation. The physician is asked to make diagnostic decisions and evaluations of the extent of the stroke, and to plan for patient management.

The course has been approved by the American Academy of General Practice for 16 hours of prescribed credit. It is being presented by the American Rehabilitation Foundation.

Enrollment is limited to 20 physicians. Applications will be accepted in the order received. Tuition is $50. To receive information or make application, write: Thomas P. Anderson, M.D., Kenny Rehabilitation Institute, 1800 Chicago Ave., Minneapolis, Minn. 55404.

Clinical Reviews, Mayo Clinic

The Staff of the Mayo Clinic and the Faculty of the Mayo Foundation are presenting Clinical Reviews Nov. 6–8 and again Nov. 13–15. Because of the large number attending in past years, two identical sessions on successive weeks have been planned.

The program of lectures and discussions on problems of general interest in medicine and surgery will be held in the Theater of the Mayo Civic Audi-

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torium, Rochester, Minn. It is acceptable for credit by the American Academy of General Practice and the College of General Practice of Canada. Registration fee is $10. Communications to: Mr. M. G. Brataas, Mayo Clinic, Rochester, Minn., indicating which session is preferred.

Subjects include: Medical Treatment of Emphysema, Surgical Treatment of Emphysema, Suicide, The Non-talking Child, Pitfalls in Vein Surgery, Malignant Melanoma of the Head and Neck, Banding Procedure for Hemorrhoids, Treatment of Inadequate Respiration, Common Lesions of the Oral Mucosa, Contact Dermatitis, Surgical Treatment of Chronic Otitis Media, Current Therapy of Acute and Chronic Leukemia, Evaluation of the Bleeder, Evaluation of Anemic Patients;

Intensive Care Units, Osteoporosis—Diagnostic Considerations and Managements, Demonstration of the Neurologic Examination in Adults and Children, Alcoholism, Pulmonary Embolism, Granulomatous Arteritis, Diagnostic Significance of Dizziness, Recognition and Management of Subtle Convulsive Disorders, Indications for Coronary Angiography, Coronary Angiography Procedure, Myocardial Revascularization Operation;

Roundtable Discussions—Common Dystocia Problems of Obstetrics, Fractures of the Tibia, Examination of the Hand, When is Varicose Vein Surgery Necessary?, Carpal Tunnel Syndrome, Medical Treatment of Hypertension, Surgical Emergencies in Children, Current Treatment of Gout;

Kidney in Hepatic Failure, Surgical Treatment of Chronic Ulcerative Colitis, Use of Atromid-S in the Treatment of Hyperlipemia, Management of Aortoiliac Occlusive Disease, Treatment of Inoperable Lung Cancer, Chemotherapy of Gastrointestinal Malignancies, Medical Treatment of Cancer of the Breast;

Panels—Present Treatment of Rh Problems and Speculation of Future Management; Chest Trauma; Splints, Traction and Positioning; Kidney Disease in Children;

Pets and Parasites, Diagnostic Uses of Radioisotopes, Oral Hypoglycemic Agents in Treatment of Diabetes, Evaluation and Treatment of Common Problems in Vaginitis, Effect of Medications on Thyroid Function, Evaluation of Thyroid Nodule, Surgical Treatment of the Thyroid;

Craniofacial Pain, Surgical Treatment of Carcinoma of Cervix, Worn Out Knee, Foot Problems in Children, Growth Abnormalities, Prevention and Treatment of Rheumatic Fever, and Psychedelics.

Learning Disorders in Children

Medical and educational aspects of learning disorders in children, recently identified as a major handicapping problem, will be the subject of a seminar to be held Nov. 17 and 18 at the annual convention of the National Society for Crippled Children and Adults in the Century Plaza Hotel, Los Angeles.

The seminar will bring together leading authorities in all areas concerned with the problem. It will present the advantages of the team approach in dealing with the diagnosis and education of children suffering from conceptual-perceptual handicaps, and will include most recent information and data gathered in the National Project on Minimal Brain Dysfunction.

The seminar, an outstanding feature of the three-day convention program, will occupy two half-days and will be directed to special educators, school nurses, psychologists, speech pathologists, occupational therapists and parents. A special invitation is extended to these groups.

College of Surgeons Meetings

The American College of Surgeons will hold its first of three 1968 Sectional Meetings in Dallas, Feb. 19–21. More than 400 surgeons are expected to attend this concentrated, three-day program, open to all doctors of medicine.

This is the first ACS meeting in Dallas since 1958. Headquarters will be the Statler–Hilton Hotel.

Under the chairmanship of Dr. Robert S. Sparkman, Dallas, the local advisory program committee has planned an intensive series of panels, "How-I-Do-It" Clinics, symposia, scientific papers, and films designed to inform the medical profession at large about developments in surgery.

Approximately 100 participants—surgeons of outstanding ability—will serve as teachers, focusing attention on newer ways of handling everyday problems in general surgery and the specialties of proctology, plastic, urology, and obstetrics and gynecology.

This program of short meetings, held in different sections of the country, pioneered in 1920, and was an immediate success. In keeping with the philosophy of the College that the doctor never stops learning, these meetings report acceptable treatment, new treatment, and research in progress.

Interim Clinical Meeting, Chest Physicians

The American College of Chest Physicians will hold an Interim Clinical Meeting at the Warwick Hotel, Houston, Tex. Nov. 25–26.

This program will consist of a two-day scientific program with roundtable discussions and fireside conferences. A highlight of this program will be a panel discussion held at the NASA Manned Spacecraft Center.

SUBJECT: "Cardiorespiratory System and Space Flight"

MODERATOR: Charles A. Berry, M.D.
Chief of Center Medical Programs

This meeting is just prior to the American Medical Association Clinical Meeting, Nov. 26–29.

For a copy of the program and other details please write to the Executive Office of the American College of Chest Physicians, 112 East Chestnut St., Chicago, Ill. 60611.

"Frontiers in Medicine," Chicago

The third annual "Frontiers of Medicine" series for practicing physicians will be presented at The University of Chicago Hospitals and Clinics beginning Oct. 11.

Individual programs in the series will be presented the second Wednesday of each month through May 1968.

The programs will be presented mainly by the clinical faculty of The University of Chicago School of Medicine. Guest lecturers from neighboring institutions will take part in several programs.

The series is designed to give physicians who have been in practice for several years a comprehensive view of recent developments in various areas of medicine. Particular attention is given to clinical applications. The series is accredited for 24 prescribed hours by the American Academy of General Practice.

All sessions will begin at 2 PM in Room P-117, Billings Hospital, 950 East 59th Street, Chicago.

The series is presented by the University's Committee on Continuing Medical Education, under the chairmanship of Dr. Joseph B. Kirsner, Professor of Medicine and Chief of the Section of Gastroenterology.

Individual programs and dates are scheduled as follows: *Oct. 11*, Diabetes Mellitus, Common Gynecological Problems; *Nov. 8*, Clinical Allergy and Immunology; *Dec. 13*, Shock; *Jan. 10*, Mental Retardation—Modern Approaches; *Feb. 14*, Some New Views in Dermatology; *Mar. 13*, Management of Inoperable Cancer; *Apr. 10*, Treatment of Cardiac Emergencies; and *May 8*, Eye Disease—Where Do We Stand?.

Further details on the programs and information on registration are available from David M. G. Huntington, Administrative Coordinator, Committee on Continuing Medical Education, The University of Chicago, 950 East 59th Street, Chicago (MUseum 4-6100, extension 5272).

American College of Chest Physicians

The ACCP has announced its 1967–1968 postgraduate program as follows:

No. 2: *Clinical Cardiopulmonary Physiology*, Knickerbocker Hotel, Chicago, Ill., November 6–10.

No. 3: *Diagnosis and Treatment of Diseases of the Heart and Lungs*, Barbizon–Plaza, New York City, November 13–17.

No. 4: *Clinical Application of Cardiopulmonary Physiology*, Ambassador Hotel, Los Angeles, Calif., Feb. 12–16, 1968.

No. 5: *Diagnosis and Treatment of Cardiovascular and Pulmonary Diseases*, Hotel Fontainebleau, Miami Beach, Fla., Mar. 4–8, 1968.

No. 6: *Cineangiographic Techniques in Cardiovascular Disease*, Cleveland Clinic, Cleveland, O., Apr. 29, 30, May 1, 1968.

For further information regarding the above courses, contact the American College of Chest Physicians, 112 East Chestnut Street, Chicago, Ill. 60611.

AMA Clinical Convention Nov. 26–29

A scientific program especially designed for the physician in practice again will be featured at the AMA's Clinical Convention, to be held in Houston, Tex., Nov. 26–29.

The four-day meeting will include scientific sessions on 18 major topics, four postgraduate courses, breakfast roundtable conferences, closed-circuit television and medical motion picture programs, and more than 150 scientific exhibits.

Of special interest are the post graduate courses, expanded to four topics: Fluid and Electrolyte Balance, Oncology, Cardiovascular Disease, and Obstetrics and Gynecology. Each course will consist of three half-day sessions featuring outstanding teachers.

Scientific and industrial exhibits and all scientific meetings will be in Houston's new Astro Hall, a part of the Astrodome complex.

Topics at the general scientific sessions include: aerospace medicine, antibiotics, arthritis, cancer, cardiovascular medicine, cardiovascular surgery, dermatology, endocrinology, gastroenterology, general surgery, genitourinary treatment, geriatrics, obstetrics and gynecology, ophthalmology, otolaryngology, pediatrics, and psychiatry. There also will be a session on "new cares" featuring a discussion of legal and social problems now faced by the physician.

Breakfast Roundtable Conferences will discuss (1) Indications and Limitation of Uses of Antibiotics, (2) "The Moral and Ethical Aspects of Caring for the Dying Patient," (3) "Management of Cerebrovascular Insufficiency," and (4) Adolescence, Age of Rebellion; Some Related Psychiatric Aspects." Numbers 1 and 2 will be Tuesday morning, Nov. 28; numbers 3 and 4 will be Wednesday morning, Nov. 29. Tickets will be $3 each.

An outstanding program of closed-circuit color television and more than 25 medical motion pictures will be presented. Live, color television broadcasts of surgery and discussions from Houston's Hermann Hospital will be seen on a large screen in Astro Hall. Medical motion pictures will include three or four premier showings, plus several films that were well received at the AMA annual convention last June.

The AMA House of Delegates will meet at the Shamrock–Hilton Hotel.

The Ninth National Conference on the Medical Aspects of Sports will be Sunday, Nov. 26, at the Hotel America in conjunction with the Clinical Convention. Sponsored by the AMA Committee on the Medical Aspects of Sports, the meeting will feature morning, afternoon, and evening discussions of problems faced by team physicians at all levels of athletic competition.

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MEDICAL MEETINGS *continued*

1967 Dearholt Lectures

Dr. J. Max Chamberlain, associate clinical professor of surgery at Columbia University, has accepted an invitation to deliver the 1967 Dearholt lectures. He will speak at the University of Wisconsin in Madison on Nov. 7 and at Milwaukee County General Hospital in Milwaukee on Nov. 8.

Doctor Chamberlain received his medical degree from the University of Colorado and did advanced study at the University of Michigan. The thoracic surgeon interned at Massachusetts General Hospital in Boston.

Dearholt lectures are presented annually to give practicing physicians and students at Wisconsin's medical schools an opportunity to see and hear outstanding leaders of the medical profession. They are sponsored by Marquette University, the University of Wisconsin, the Wisconsin Anti-Tuberculosis Association and the Wisconsin Thoracic Society.

Marshfield Clinic Seminar, Nov. 4

The Marshfield Clinic Foundation for Medical Research and Education will present a seminar on "The Doctor's Assistant Tomorrow," Nov. 4 at St. Joseph's Hospital Nursing School Auditorium. This seminar is designed to provoke new ideas of effective medical care.

Guest speakers will be: Darrel J. Mase, Ph.D., Dean, College of Health Related Professions, University of Florida, Gainesville; Warren Resh, Esq., State Bar of Wisconsin, Madison; Norbert E. Koopman, Ph.D., Dean, University of Wisconsin, Wood County Center, Marshfield; Daniel Stoffel, Personnel Manager, Sentry Insurance, Stevens Point; and Miss Beatrice Palen, Supervisor of Health Occupations, State Board of Vocoational, Technical and Adult Education, Madison.

Program chairman is Dr. Francis N. Lohrenz, President of the Foundation. Registration fee: $5. Contact: Mrs. Janet Knauf, Marshfield Clinic, 630 South Central Ave., Marshfield, Wis. 54449.

Medical Directors Group to Meet

The first annual meeting of the International Society of Medical Directors of Chronic Disease Facilities will be held Nov. 30 in the Warwick Hotel, Houston, Tex., immediately following the AMA clinical meetings. For information: Patricia Dorr, Executive Director, ISMDCDF, 360 North Michigan Ave., Suite 1003, Chicago, Ill. 60601.

Michigan Internists Meeting

Specialists in internal medicine in Michigan will hold a scientific meeting in Ann Arbor, Oct. 27–28, under auspices of the American College of Physicians. Information from: Noyes L. Avery, Jr., M.D., 515 Lakeside Dr., S.E., Grand Rapids, Mich. 49506.

This pain is getting on my nerves.

Patients in pain often experience concomitant anxiety and tension, which may add to the burden of pain.

For such patients, you may want to prescribe a preparation that offers more than simple analgesia.

A good choice is often EQUAGESIC® (meprobamate and ethoheptazine citrate with aspirin). It helps relieve pain. And anxiety. And skeletal muscle spasm as related to pain or anxiety and tension.

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Contraindications: History of sensitivity or severe intolerance to aspirin or meprobamate.

Warnings: USE IN PREGNANCY: Safety for use during pregnancy or lactation has not been established; therefore it should be used in pregnant patients or women of child-bearing age only when the physician judges its use essential to the patient's welfare.

Precautions: Keep out of reach of children. Not recommended for patients 12 years old or less. Carefully supervise dose and amounts prescribed, especially for patients prone to overdose themselves. Excessive prolonged use of meprobamate may result in dependence or habituation in susceptible persons—as alcoholics, ex-addicts, severe psychoneurotics. Withdraw gradually after prolonged high dosage to avoid possibly severe withdrawal reactions including epileptiform seizures. Warn patients of possible reduced alcohol tolerance. If drowsiness, ataxia or visual disturbances (impairment of accommodation and visual acuity) occur, reduce dose. If symptoms persist, caution patients against operating machinery or driving. After meprobamate overdose, prompt sleep, reduction of blood pressure, pulse and respiratory rates to basal levels, and hyperventilation are reported. Give cautiously to patients with suicidal tendencies. Treat attempted suicide (has resulted in coma, shock, vasomotor and respiratory collapse and anuria) with immediate gastric lavage and appropriate supportive therapy (CNS stimulants and pressor amines as indicated).

Side Effects: Ethoheptazine and aspirin may occasionally cause nausea, vomiting, epigastric distress, and rarely dizziness. Overdosage may result in CNS depression (drowsiness and lightheadedness) or CNS stimulation and salicylate intoxication (requires induced vomiting or gastric lavage, specific parenteral electrolyte therapy for ketoacidosis and dehydration, and observation for hypoprothrombinemic hemorrhage [usually requires whole blood transfusions]). Meprobamate may cause drowsiness, ataxia and rarely allergic or idiosyncratic reactions. These reactions, sometimes severe, can develop in patients receiving only 1 to 4 doses who have had no previous contact with meprobamate. Mild reactions are characterized by urticarial or erythematous maculopapular rash. Acute nonthrombocytopenic purpura with petechiae, ecchymoses, peripheral edema and fever have been reported. If allergic reaction occurs, meprobamate should be stopped and not reinstituted. Severe reactions, observed very rarely, include angioneurotic edema, bronchial spasms, fever, fainting spells, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case) and hyperthermia. Treat symptomatically such as with epinephrine, antihistamine and possibly hydrocortisone. A few cases of leucopenia, usually transient, have been reported following continuous use. Rarely, cases of aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis, and hemolytic anemia have been reported; almost always, in the presence of known toxic agents.

Composition: 150 mg. meprobamate, 75 mg. ethoheptazine citrate and 250 mg. aspirin per tablet.

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WISCONSIN WORK WEEK OF Health

OCTOBER 16-20, 1967

FIFTH ANNUAL PROGRAM

SPONSORED BY THE STATE MEDICAL SOCIETY OF WISCONSIN

All sessions will be held in the State Medical Society Headquarters in Madison. This year over 30 firms, organizations, and agencies join the State Medical Society in cosponsoring this important event. All sessions are open to the general public. Encourage the interested people in your community to attend . . . and plan to attend yourself! Daily programs begin at 9:15 a.m., adjournment at 4 p.m. No registration fee. Luncheon provided.

PROGRAM

MONDAY, OCTOBER 16: Medical Aspects of Traffic Safety and Rescue

THE ROLE OF MEDICAL CONDITIONS IN ACCIDENT CAUSATION: *James L. Karns*, Director, State Motor Vehicle Dept.

DETECTION OF THE MEDICALLY IMPAIRED DRIVER: *James L. Weygandt, M. D.*, Chairman, SMS Division on Safe Transportation

AUTOMOBILE DESIGN FOR SAFETY—LIP SERVICE OR REALITY?: (to be announced)

SPECIAL PROBLEMS OF THE MOTORCYCLE BOOM: *Richard C. Dillihunt, M. D.*, Maine Medical Center, Portland, Me.

RESCUE OF ACCIDENT VICTIMS IN RURAL AREAS: *Joseph D. Farrington, M. D.*, Minocqua

RESCUE OF ACCIDENT VICTIMS IN METROPOLITAN AREAS: *Mr. Ed Rostkowski*, Department of Public Works, Milwaukee

COMMUNICATIONS IN RESCUE EFFORTS: *Capt. John M. Waters, Jr.*, U. S. Coast Guard, Washington, D. C.

Following adjournment, a meeting will be called of the Commission on Health Information and the Commission on Safe Transportation.

TUESDAY, OCTOBER 17: Special Medical and Operational Problems in Nursing Home Administration

BIRD'S-EYE VIEW OF NURSING HOMES AND HOMES FOR THE AGED IN WISCONSIN: *Mr. Dale Jennerjohn*, State Dept. of Health and Social Services

THE JOINT COMMISSION APPROVES EXTENDED CARE FACILITIES: *John D. Porterfield, III, M. D.*, Director, Joint Commission, Chicago

CHANGING MEDICARE STANDARDS FOR PARTICIPATION BY EXTENDED CARE FACILITIES: *Milton Bankoff, M. D.*, Dept. Chief, Nursing Home Branch, Division of Medical Care Administration, USPHS, Washington, D. C.

MEDICAL AND NURSING SPECIALIZATION IN THE EXTENDED CARE FACILITY: *Margie S. Davis, R. N.*, Davis Nursing Home, Denver, Colo.

WHAT THE EXTENDED CARE FACILITY EXPECTS FROM THE PHYSICIAN AND THE NURSE: *Rev. C. A. Becker*, President, American College of Nursing Home Administrators, Racine

HEALTH INSURANCE BENEFITS FOR EXTENDED CARE: *Mr. Louis Orsini*, Director, Health Insurance Council, New York

WEDNESDAY, OCTOBER 18: Scientific, Philosophical, and Ethical Considerations in Life Extension

WHO SHALL LIVE—WHO SHALL DIE?: *J. Ernest Breed, M. D.*, Chicago

SHOULD THE PATIENT'S WISHES BE CONSIDERED?: *John A. Spitell, M. D.*, Mayo Clinic, Rochester

VIEWPOINT OF THE THEOLOGIAN: *C. R. Stinnette, Th. D.*, Joint Professor of Pastoral Theology and Psychiatry, University of Chicago Divinity School

WHAT IS LEGAL?: *Edwin J. Holman, LL. B.*, Department of Medical Ethics, AMA

CASE PRESENTATION: *W. W. Stead, M. D.*, Professor of Medicine, Marquette U. School of Medicine

REACTOR PANEL: *John B. Toussaint, M. D., Mr. John A. Kluwin, Rev. James R. Gillis, O. P.*

THURSDAY, OCTOBER 19: The Role of the Nurse

TRENDS IN NURSING TRAINING: (to be announced)

THE SPECTRUM OF PATIENT CARE VIEWED BY THE NURSE: *Eleanor C. Lambertsen, Ed. D., R. N.*, Director, Division of Nursing Education, Columbia U. Teachers College, New York

PHYSICIAN–NURSE RELATIONSHIPS: *Hans O. Mauksch, Ph. D.*, Dean, Liberal Arts, IIT, Chicago

REACTOR PANEL: *L. I. Stein, M. D.*, Mendota State Hospital; *John Rankin, M. D.*, UW Medical School; *Rose Marie Chioni, R. N.*, UW School of Nursing; *Mrs. Carol Lindeman, R. N.*, Eau Claire State U. School of Nursing

LIABILITY OF THE MD AND NURSE IN PATIENT CARE: *Nathan Hershey*, Assistant Director of Health Law, University of Pittsburgh

Following adjournment, a meeting will be called of the Commission on Hospital Relations and Medical Education

FRIDAY, OCTOBER 20: Community Resources in Rehabilitation of the Mentally Ill and Retarded

PANEL ON FIRST FRIENDS, HALFWAY HOUSES, DAY PROGRAMS, AND COMMUNITY MENTAL HEALTH CENTERS: *Rev. Richard Larson*, Madison; *Mr. Walter Conner*, Eau Claire; *Mr. Robert Hall*, Madison; *Mr. C. A. Cahill*, Racine

REACTOR PANEL: *D. A. Treffert, M. D.*, Superintendent, Winnebago State Hospital; *R. L. Lenz*, Mental Health Consultant, State Dept. of Public Welfare; *E. H. Jochimsen, M. D.*, Sheboygan

J. L. Karns

H. O. Mauksch, PhD

Rev. Richard Larson

Nathan Hershey

Walter Conner

E. C. Lambertsen, EdD

J. E. Breed, MD

W. W. Stead, MD

ROLE OF WORK IN THE REHABILITATION OF THE MENTALLY HANDICAPPED: *Adrian E. Towne*, Administrator, Division of Vocational Rehabilitation, State Dept. of Health and Social Services

COMPREHENSIVE COMMUNITY MENTAL HEALTH CENTERS IN WISCONSIN: *Kenneth H. Rusch, M. D.*, Community Services Director, Division of Mental Hygiene, State Dept. of Health and Social Services

SUMMATION AND DISCUSSION: *Milton H. Miller, M. D.*, Dept. of Psychiatry, UW Medical School

SUPPORT YOUR FOUNDATION

It is your opportunity to give financial assistance to the charitable, educational and scientific aspects of medicine as they relate to the health and well-being of the people of Wisconsin. Gifts may take a number of forms such as cash, life insurance, securities, land, books, instruments, stamp and coin collections, works of art and other artifacts. Some physicians are making the Foundation a beneficiary of their wills. In any event, all contributions to the Foundation are deductible for income tax purposes. Checks may be made out to: CES Foundation, and sent to CES Foundation, State Medical Society of Wisconsin, Box 1109, Madison, Wisconsin 53701.

Remember for November!

"THE HIGH COST OF QUACKERY in Lives and Money"

MONDAY & TUESDAY, NOVEMBER 13 & 14
Milwaukee Auditorium

A two-day public meeting aimed at warning the people of Wisconsin against the quacks and their come-on's which annually bilk Americans of over $1,000,000,000. Important to you, as a physician; to your patients; to *all* business, civic, and professional leaders.

Among the Featured Speakers:

MAURINE NEUBERGER	Former United States Senator Neuberger is now special consultant on consumer relations to James L. Goddard, M.D., Commissioner, U.S. Food and Drug Administration.
JERRY WALSH	Mr. Walsh is a member of the executive board of the National Arthritis and Rheumatism Foundation, New York.
JOHN W. MINER	Mr. Miner is head of the medicolegal section of the district attorney's office, Los Angeles county, California. He was instrumental in drafting the bill, passed in August by the California legislature, making it a felony in that state to practice medicine without a license "under circumstances which create risks."
NORMA LEE BROWNING	Long a feature writer for *The Chicago Tribune*, Miss Browning has written several perceptive exposes of quacks, in both physical and mental health areas, after visiting them as a "patient".
C. H. HARDIN BRANCH, M.D.	Doctor Branch, of the University Medical Center, Utah, is a past president of the American Psychiatric Association and is president of the research committee of the National Association for Mental Health, Inc.
MRS. MARTY MANN	Founder and executive director of The National Council on Alcoholism, New York, Mrs. Mann is a fellow in the American Public Health Association, the Society of Public Health Educators, and England's Royal Society of Health. She holds an honorary fellowship in the American Psychiatric Association. A recovered alcoholic herself, Mrs. Mann speaks with authority not only on alcoholism but also on the quacks who attempt to sell "cures" for the problem.
FREDRICK J. STARE, M.D.	Doctor Stare, a native of Wisconsin, is with the department of nutrition, School of Public Health, Harvard university.
HOWARD HUSH	Mr. Hush is Executive Director of Family Service of Metropolitan Detroit, a leader in the field of family counseling, and experienced in combating the damage done by ill-equipped "counselors" who infiltrate the field.

Continued on next page

Dr. Treffert Heads New Addiction Unit

The State Medical Society's newly created Division on Alcoholism and Drug Addiction will be headed by Dr. Darold Treffert, superintendent of Winnebago State Hospital. His appointment to the chairmanship was made by Society president, Dr. Harold J. Kief of Fond du Lac following discussion and recommendations at the Council meeting held July 30 at Society headquarters in Madison. The new division was created from the Division on Nervous and Mental Diseases of the Commission on State Departments.

Dr. D. A. Treffert

Doctor Treffert is now recruiting eight members from the Society to serve with him in the division which will meet three or four times during the year. The division is charged with the responsibility to act as liaison in the addiction field between the state government departments involved in health areas and the medical profession.

State agencies, social agencies, and the medical profession will direct questions of addiction to the new division. It will provide consultation and proposals in legislative matters, public information, serve as a receptacle for information and specific medical knowledge, as well as perform its liaison function with state and health agencies.

Doctor Treffert's interest in alcoholism and drug addiction is well known. In October 1965, he opened and staffed a 42-bed alcoholism treatment unit at Winnebago State Hospital. Since that date there have been 800 admissions and the unit has grown from an area in one building to a two-floor area in another building of the State Hospital complex, with a 56-bed capacity. Dr. George Lysloff has been full director of the unit since October 1966.

Doctor Treffert came to Winnebago State Hospital in July 1962 as head of children's services and became superintendent in 1964. He received his premedical training at Bethany College, Mankato, Minn., and the University of Iowa, Iowa City. After graduating from the University of Wisconsin Medical School, he filled a psychiatric residency post at University Hospitals in Madison. Prior to that time he was a member of the Sacred Heart Hospital medical staff, Eugene, Ore.

Commission on Medical Care Plans

At the meeting of the Commission on Medical Care Plans, held Aug. 4–5 at Hayward, Dr. Robert Krohn of Black River Falls was reelected vice-chairman of the Commission. Dr. J. T. Sprague and Dr. R. A. Sievert, both of Madison, were reelected treasurer and assistant treasurer, respectively.

Dr. D. N. Goldstein of Kenosha was appointed a voting delegate to the National Association of Blue Shield Plans and an observer at AMA meetings. Dr. W. T. Casper of Milwaukee was named as his alternate.

Annual Meeting of Foundation Trustees

Members of the Board of Trustees of the Charitable, Educational and Scientific Foundation met at Society headquarters in Madison June 29 for their annual meeting.

In election of officers, Dr. William D. Stovall, Madison, was reelected president; Dr. W. J. Egan, Milwaukee, Vice-president, succeeding Dr. A. J. McCarey, Green Bay, who has retired; and Dr. L. C. Pomainville, Wisconsin Rapids, treasurer, succeeding Dr. Gordon J. Schulz, Union Grove, who had asked to be relieved of his duties. Mr. C. H. Crownhart, secretary of the State Medical Society, continues as secretary of the Foundation.

Mr. Norman J. Salt is director of the Foundation. Mr. H. B. Maroney, III, has been named assistant secretary of the Foundation.

MEETINGS AND SPECIAL EVENTS HELD AT THE STATE MEDICAL SOCIETY "HOME" DURING THE MONTH OF AUGUST 1967

1 Board of Trustees, Dane County Medical Society
2 Planning Committee, Wisconsin Regional Medical Program
3 Heart Study Committee, Wisconsin Regional Medical Program
3 Council on Health (formerly State Board of Health) (Madison)
4 Commission on Medical Care Plans (Hayward)
5 Commission on Medical Care Plans (Hayward)
7 Committee on Legislation, Wisconsin Association of Professions
9 Commission on State Departments
10 Examination for Trained Practical Nurses, State Department of Nurses
22 Insurance Advisory Committee, Dane County Medical Society
26 Maternal Mortality Study Committee, Division on Maternal and Child Welfare of the Commission on State Departments (Milwaukee)
31 Commission on Hospital Relations and Medical Education

Meetings not held in the Society "Home" but have a direct relationship are printed in italics, with the location in parentheses.

The trustees authorized release of restrictions from various student loan funds, such as requirement of residency in a certain county, providing approval is obtained from the donors and the county medical societies who established the funds.

In the name of the Board of Trustees it was agreed that solicitation be made to the Wisconsin Heart Association for donations toward construction of a "walk-in heart" proposed for the Museum at Prairie du Chien.

Trustees were given a status report of student loans. Total amount loaned is $153,986.27 and this includes loans to 114 medical students, 8 nursing students, 1 pharmaceutical student, and 4 dental students.

Contributions to the Foundation by members of county medical societies for the period January 1, 1967, through May 31, 1967, were reported at $21,994.00. During the same period contributions from medical societies totaled $8,403.55 and from other organizations and individuals, $6,097.00. Total contributions amounted to $36,494.55.

Foundation Helps Build Historical Doctor's Office

The Society's Charitable, Educational and Scientific Foundation has given $6,000 to the State Historical Society to cover design and part of the construction costs of a doctor's office being planned for Stonefield, village of the 1890s located in Nelson Dewey State Park near Cassville.

DR. WILLIAM D. STOVALL, president of the CES Foundation, presents a check for $6,000 to Frederic E. Risser, a curator of the State Historical Society, as part of the design and construction cost for a doctor's office at Stonefield, village of the 1890s in Nelson Dewey State Park near Cassville.

The presentation was made by Dr. William D. Stovall, Madison, president of the Foundation, to Frederic E. Risser, Madison attorney, and member of the Historical Society's Board of Curators and chairman of its Historic Sites Committee, at the Foundation's Board of Trustees meeting June 29 at Society headquarters.

In accepting the check Mr. Risser said, "It's a wonderful feeling to know that the doctors of the State Medical Society are working together with the State Historical Society, and we will continue to work together as a team until this project is fully completed."

The $6,000 was raised by the Foundation in cooperation with the Woman's Auxiliary to the State Medical Society.

According to Raymond S. Sivesind, director of sites and markers for the Historical Society, the doctor's office will be located in two rooms of his private residence as was customary in that day. It will be modeled in appearance after a typical late Victorian small-town American home. Total cost of the project is estimated at $20,000. Furnishings and instruments for the doctor's office have been contributed by several state physicians or their descendants.

The Society, through its Foundation, is seeking additional funds for the project. Persons interested in contributing to the project are asked to write to the CES Foundation, Box 1109, Madison 53701.

Society Re-activates Role with Medical Student Group

The Council, at its July meeting, approved several measures to improve and re-activate its liaison with the Student American Medical Association.

The Society will become a sustaining member of SAMA. It will provide a monthly report to students via the student newsletters which are published at the Society headquarters, and the two chapters will be given the opportunity to develop a special page feature monthly in the WISCONSIN MEDICAL JOURNAL for reporting to physicians. The Society will offer staff representation at SAMA meetings to provide advice in the socio-economic aspects of their activities. The Society will make its services available to set up programs and speakers for medical student meetings if desired. The Society will develop programs of a semi-informal nature in which the medical student and his wife or fiancee are presented with the practical aspects of medical care.

The Society also endorses the proposal to develop a method of increasing summer jobs. The Society is increasing financial aid as needed to increase the ability of student officers to participate in important meetings of the Society, SAMA, and AMA.

Drs. Beckman and Quick Given First Copies of Commemorative Issues

At a small luncheon ceremony in Milwaukee Saturday, August 5, the first copies of the July issue of the WISCONSIN MEDICAL JOURNAL were presented to Dr. Harry Beckman and Dr. Armand J. Quick, in whose honor the July and August issues were dedicated. Overwhelmingly surprised and humbly pleased with the special recognition, the two doctors were brought together for a joint CPC of Columbia and St. Mary's hospitals at St. Mary's. Making the presentation on behalf of the JOURNAL and the State Medical Society were Drs. David W. Ovitt and M. C. F. Lindert, members of the JOURNAL's Editorial Board and co-chairmen of the special issues.

The special issues, called "festschrifts," are a compilation of scientific articles and tributes written by students, colleagues, and admirers to honor and recognize these two Milwaukee physicians who have gained national and international reputations in their respective field—Doctor Beckman in pharmacology and Doctor Quick in biochemistry.

This is the third such commemorative issue published by the JOURNAL in recent years. Previously honored were Dr. William D. Stovall in 1961 and Dr. William S. Middleton in 1964.

DOCTOR HARRY BECKMAN (left center) and Dr. Armand J. Quick (right center) were completely surprised and pleasantly overwhelmed early in August when they were presented the first copies of the July issue of the WISCONSIN MEDICAL JOURNAL *which was dedicated to them in recognition of their outstanding contributions to the science of medicine, the art of healing, and the education of others. Making the presentation were Dr. David W. Ovitt (left) and Dr. M. C. F. Lindert (right), who were co-chairmen of the July and August special issues.*

Dr. Huth, Baraboo, New Councilor

The Council elected Dr. M. F. Huth of Baraboo to the unexpired term on the Council of Dr. Milton D. Davis of Milton who died July 19. (A resolution in commemoration of Doctor Davis appeared in the August issue.)

Doctor Huth has served in a number of capacities with various committees of the Society, among them the Committee on Grievances, Commission on Scientific Medicine, the Civil Defense committee, and Editorial Board of the WISCONSIN MEDICAL JOURNAL.

Dr. M. F. Huth

He is a past president and secretary of the Sauk County Medical Society, and is active in the Wisconsin and American heart associations.

Doctor Huth is a graduate of the University of Wisconsin Medical School and a member of the medical staff of St. Clare's Hospital, Baraboo, where he has been in general practice for 30 years. He served on active military duty during World War II from 1941 to 1946 and is recipient of the Bronze Star medal. He presently is a colonel in the active U.S. Army Reserve.

* * *

AMONG NEARLY 26 MILLION U.S. veterans are 15,000 post-Korean veterans under 20 years of age and 9,000 Spanish–American War veterans 89 years of age and older, according to the Veterans Administration.

Physician Attendance Vital to Success

Physician attendance at the Wisconsin Work Week of Health, Oct. 16–20, is a most important factor in the ultimate success of this public-oriented program which attracts some 1500 persons annually to the State Medical Society "home" in Madison.

Although the program will be concerned mainly with those in health services allied to medicine, there will be opportunites throughout the week for physicians to integrate their presence and thinking with others on the "health team."

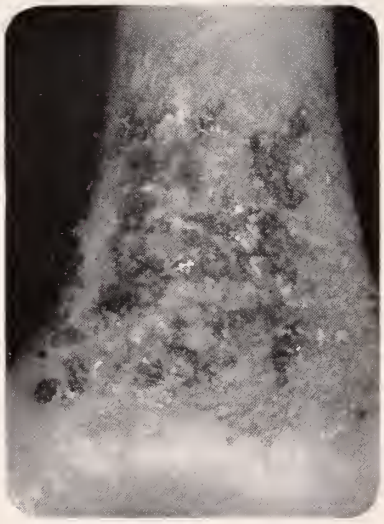
The Work Week of Health—a series of conferences to assess current status and future planning in a number of health areas—is dovetailed with the Community Health Week activities, a nationally recognized event sponsored by the American Medical Association in cooperation with state and county medical societies.

Several thousand invitations are being extended to each segment of the state's population interested in the subject presented on a specific day. The intense interest of these people in past years has been a continual stimulus in the development of successive programs, some of which have been recommended by those in attendance.

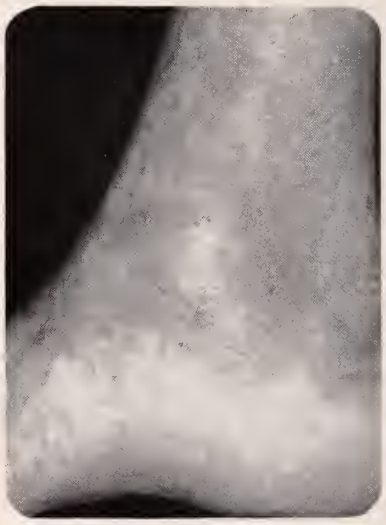
The Work Week of Health represents one of the most ambitious undertakings of the State Medical Society to provide information and initiate action in a wide field of health topics. I strongly urge every physician in Wisconsin to seriously consider his presence sometime during this week. It will be a rewarding and highly valuable experience.

—HAROLD J. KIEF, M.D., *President*
State Medical Society of Wisconsin

Eczema of many years... controlled in two weeks



Before treatment



After treatment — with ARISTOCORT Topical Ointment 0.1% for two weeks

ARISTOCORT® Triamcinolone Acetonide Topicals have proved exceptionally effective in the control of various forms of eczema: allergic, atopic, nummular, psoriatic, and mycotic.

In most cases responsive to topical ARISTOCORT, the 0.1% concentration is sufficiently potent. The 0.5% concentration provides enhanced topical activity for patients requiring additional potency for proper relief.

Administration and Dosage: Apply sparingly to the affected area 3 or 4 times daily. Some cases of psoriasis may be more effectively treated if the 0.1% Cream or Ointment is applied under an occlusive dressing.

Contraindications: Tuberculosis of the skin, herpes simplex, chicken pox and vaccinia.

Precautions and Side Effects: Do not use in the eyes or in the ear (if drum is perforated). A few individuals react unfavorably under certain conditions. If side effects are encountered, the drug should be discontinued and appropriate measures taken. Use on infected areas should be attended with caution and observation, bearing in mind the potential spreading of infection and the advisability of discontinuing therapy and/or initiating antibacterial measures. Generalized dermatological conditions may require systemic corticosteroid therapy. Steroid therapy, although responsible for remissions of dermatoses, especially of allergic origin cannot be expected to prevent recurrence. The use over extensive body areas, with or without occlusive nonpermeable dressings, may result in systemic absorption. Appropriate precautions should be taken. When occlusive nonpermeable dressings are used, miliaria, folliculitis and pyodermas will sometimes develop. Localized atrophy and striae have been reported with the use of steroids by the occlusive technique. When occlusive nonpermeable dressings are used, the physician should be aware of the hazards of suffocation and flammability. The safety of use on pregnant patients has not been firmly established. Thus, do not use in large amounts or for long periods of time on pregnant patients.

Available in 5 Gm. and 15 Gm. tubes and ½ lb. jars.

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Triamcinolone Acetonide
Also available in foam form.

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COUNTY SOCIETY PROCEEDINGS

DANE

The Dane County Medical Society Board of Trustees in July approved a project to be conducted by the Society in conjunction with the State Dept. of Health and Social Services and the U. S. Public Health Service, whereby any interested physician will be trained in tonometry and will receive a tonometer on loan if he does not have one. Training will be done in the physician's office and is available upon request of a physician to nurses and other interested ancillary personnel, as well as to physicians.

Following the instruction to physicians a publicity campaign will be launched in news media to encourage the public to be tested for glaucoma by their physician.

The impact of the training project and the publicity will be the subject of a study to determine effective ways of making tonometry examinations available to the public.

The annual DCMS golf tournament was held September 13 at the Stoughton Country Club.

New members of the Society include *Dr. Charles V. Ihle*, a resident in orthopedics at University Hospitals; *Dr. William G. Peterson*, an assistant professor of neurology at the University of Wisconsin Medical School and an associate in private practice with *Dr. Henry Suckle*; *Dr. Gordon A. Tuffli*, a clinical instructor in the University of Wisconsin Pediatrics Department and a practicing pediatrician with the Jackson Clinic; *Dr. George M. Sparks*, a full time consultant in ophthalmology for the State Dept. of Health and Social Services under a program sponsored by the United States Public Health Service and a clinical instructor in the Department of Surgery, University of Wisconsin Medical School, all of Madison.

DOOR–KEWAUNEE

The Door–Kewaunee County Medical Society in cooperation with the Wisconsin Heart Association sponsored a cardiac consultation clinic at the Door County Memorial Hospital in Sturgeon Bay in July. Drs. William C. Boake and *Thomas C. Meyer* examined about 25 patients who were referred to the clinic by their physicians. Doctor Boake is an internist in Madison; Doctor Meyer is a pediatric cardiologist and is assistant dean of the University of Wisconsin Medical School in Madison.

ONEIDA–VILAS

The Oneida–Vilas County Medical Society, in cooperation with the Wisconsin Heart Association, recently sponsored a congenital and rheumatic heart disease clinic at the Eagle River Memorial Hospital. *Drs. Thomas C. Puchner*, Milwaukee, and *George G. Griese*, Marshfield, examined the patients who were referred to the clinic by their family physicians.

Physicians whose names appear in italics are members of the State Medical Society.

RACINE

The Racine County Medical Society has set the date of November 5 as the time for countywide measles immunization program which has been arranged in cooperation with the State Dept. of Health and Social Services. Children from 4 to 7 years of age will be immunized.

SHAWANO

The Shawano County Medical Society and the Shawano County Public Health Service sponsored a visit of the State Dept. of Health and Social Services Mobile Survey Unit in Shawano county during the latter part of August.

TREMPEALEAU–JACKSON–BUFFALO

The Tri-County Medical Society met August 22 at the Green Meadows Supper Club near Blair. A program on an intensive care unit was conducted. Wives were guests.

UW SCIENTISTS EXHIBIT AT AMA

Stereoscopic photographs illustrating disorders of the retina found in association with diabetes are part of an exhibit prepared by three University of Wisconsin medical scientists.

By comparing the photographs and drawings made at the first clinic visit with photographs and drawings made at each subsequent visit, physicians can follow the development of retinal abnormalities, or diabetic retinopathy, a leading cause of blindness in the United States.

Composite "maps" prepared by piecing together many photographs of very small areas of the retina obtained with a special camera, are included in the exhibit, which was shown at the annual convention of the American Medical Association in Atlantic City, N. J., June 18–22.

Drawings of the retina are prepared with the aid of an ophthalmoscope. The exhibit was prepared by *Dr. Matthew D. Davis* of the UW surgery department; Miss Yvonne Magli, medical artist and photographer for UW Hospitals; and *Dr. Frank L. Myers*, resident physician in ophthalmology.

Wisconsin studies of diabetic retinopathy are supported in part by the National Institutes of Health.

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Contraindications: Infections caused by nonsusceptible organisms; history of penicillin sensitivity.

Warnings: Acute anaphylaxis (may prove fatal unless promptly controlled) is rare but more frequent in patients with previous penicillin sensitivity, bronchial asthma or other allergies. Resuscitative (epinephrine, aminophylline, pressor amines) and supportive (antihistamines, methylprednisolone sodium succinate) drugs should be readily available. Other rare hypersensitivity reactions include nephropathy, hemolytic anemia, leucopenia and thrombocytopenia. In suspected hypersensitivity, evaluation of renal and hematopoietic systems is recommended.

Precautions: In suspected staphylococcal infections, perform proper laboratory studies including sensitivity tests. If overgrowth of nonsusceptible organisms occurs (constant observation is essential), discontinue penicillin and take appropriate measures. Whenever allergic reactions occur, withdraw penicillin unless condition being treated is considered life threatening and amenable only to penicillin. Penicillin may delay or prevent appearance of primary syphilitic lesions. Gonorrhea patients suspected of concurrent syphilis should be tested serologically for at least 3 months. When lesions of primary syphilis are suspected, dark-field examination should precede use of penicillin. Treat beta-hemolytic streptococcal infections with full therapeutic dosage for at least 10 days to prevent rheumatic fever or glomerulonephritis. In staphylococcal infections, perform surgery as indicated.

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PARAMEDICAL ANCILLARY GROUPS

Milwaukee Medical Assistants Society

Mrs. Marge Belanger, president of the Milwaukee County Medical Assistants Society, conducted the first meeting of the 1967–1968 season September 19. The meeting was open to all medical personnel in Milwaukee County. Speaker was *Dr. Walter J. Woloschek*, a member of the burn team at St. Mary's Hospital in Milwaukee.

Medical Explorer Post Formed

The first Explorer Medical Specialty Post in the history of the Kettle Moraine Boy Scout Council was chartered in July during ceremonies at the Sheboygan Clinic. *Dr. Edward G. Schott*, institutional representative, accepted the charter in behalf of the sponsor—Sheboygan Clinic Foundation.

Certificates were also presented to Doctor Schott, who received his Eagle Scout badge in Cincinnati; *Dr. N. Peter Braun*, chairman, who received the King Scout badge, highest award in the British Boy Scouts Association, while a Scout in Africa; *Dr. Robert A. Keller*, *Dr. Paschal A. Sciarra*, and *Dr. James F. Hildebrand*, committee members; and *Dr. Howard A. Mueller*, post advisor.

Medical Technology Meeting

Representatives of six hospitals, affiliated with the bachelor of science in medical technology program at the Wisconsin State University—Eau Claire met July 31 and August 1 at the University. This joint meeting and others planned to take place at least every three months are made possible through a grant from the Allied Health Professions Basic Improvement program. The curriculum preparing medical technologists at Eau Claire in cooperation with the affiliated hospitals meets the requirements of the Committee of Medical Technology of the American Society of Clinical Pathologists.

Persons attending the two-day session and the institutions with which they are associated are: from Luther Hospital, Eau Claire, *Dr. Willard Aronson*, James Russell, Arnie Sorlein, Thomas Pharmakis, and Ruben C. Brown; from Sacred Heart Hospital, Eau Claire, *Dr. R. J. Fink*, Sister Patrice, and Mrs. Lucylle Esser; from St. Vincent's Hospital, Green Bay, *Dr.* and Mrs. *John L. Ford* and Sister M. Brigid; from St. Mary's Hospital, Wausau, *Dr. Richard Bartholomew* and John P. Jones; from St. Joseph's Hospital, Marshfield, Dr. F. H. Burgoyne and James Kosmicki; from Swedish Hospital, Minneapolis, Lester Johnson and Dorothy Karlen.

Paramedical Graduates Given Degrees

Ten young men and women, who recently completed courses in the Paramedical Professions at Wisconsin State University—Oshkosh, were honored at a luncheon August 2 in the Mercy Hospital, Oshkosh.

Dr. C. I. Bowerman, chief pathologist, awarded medical technology diplomas to George Dakin, Antigo; James Lewis and Mrs. Kaila St. Louis, Oshkosh; Miss Pamela Radtke, Embarrass, and Miss Karen Shingler, Clintonville.

During his congratulatory comments, Doctor Bowerman particularly commended the University and its faculty member, William Madson, for the cooperation between that institution and the Mercy staff in preparing the graduates, and Jerome Fitzgerald, clinical laboratory administrative assistant, for his work.

X-ray department graduates were presented diplomas by *Dr. D. J. Ryan*, radiologist and chief of staff. They are Miss Nancy Harra, Miss Sue Maxwell, Kenneth Rieckmann, and Mrs. Ronae Schultz, Oshkosh; and Miss Pauline Pronold, Green Bay.

Dr. D. H. McDonald of the Mercy medical staff also presented a message to the graduates.

Donations to Hemophilia Foundation

A goal of $15,000 was surpassed by $21 in August when contributors gave to the 1967 March of the Life Brigade, sponsored by the National Hemophilia Foundation of Wisconsin. The funds will be used to expand a program of distributing information to hemophiliacs and doctors, and to purchase orthopedic equipment for hemophiliacs. Money also will go for research and the establishment of regional offices within the state.

More than 4,100 volunteers participated in the drive, according to an announcement by the foundation's Wisconsin chapter.

River Pines Sanatorium

The River Pines Sanatorium in Whiting, a tuberculosis institution since its founding in 1906, has made plans for entering the nursing home field. Administrator Sister M. Adelpha has indicated that 100 beds for long-term convalescent care will be built, probably starting late in 1968 and finishing early in 1970. It is not certain whether the sanatorium will remain in the tuberculosis field.

The institution, owned and operated by the Sisters of St. Joseph, has been planning the change for a decade. About 10 years ago River Pines asked for, and received, the endorsement of the Portage County Medical Society for converting to a nursing home.

Wisconsin Epilepsy Foundation Formed

Following a report by an advisory committee of the State Department of Health, formation of a voluntary association, known as the Wisconsin Epilepsy Association, has been undertaken in an effort to work

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Physicians whose names appear in italics are members of the State Medical Society.

for better public understanding of epilepsy and its victims.

The advisory committee, whose chairman is *Dr. Francis M. Forster*, chairman of the Department of Neurology at the University of Wisconsin Medical Center, Madison, has reported that the establishment of additional clinical facilities for the treatment of epileptics in the Fox River Valley and the western and northwestern sections of the state will be required soon to provide better distribution of services to meet that substantial health problem. Treatment is now available at four specialized clinical services in Madison, Milwaukee, and Marshfield, the group reported.

Wisconsin Mental Health Meeting

The Wisconsin Association for Mental Health will hold its tenth annual leadership training institute, "Pathways to Prevention," in Madison Oct. 25 and 26 at Holiday Inn No. 2. Keynote speaker will be Dr. Thaddeus Kostrubala who participated in planning the Crisis Center and Suicide Prevention program at the Stone Brandel Foundation in Chicago.

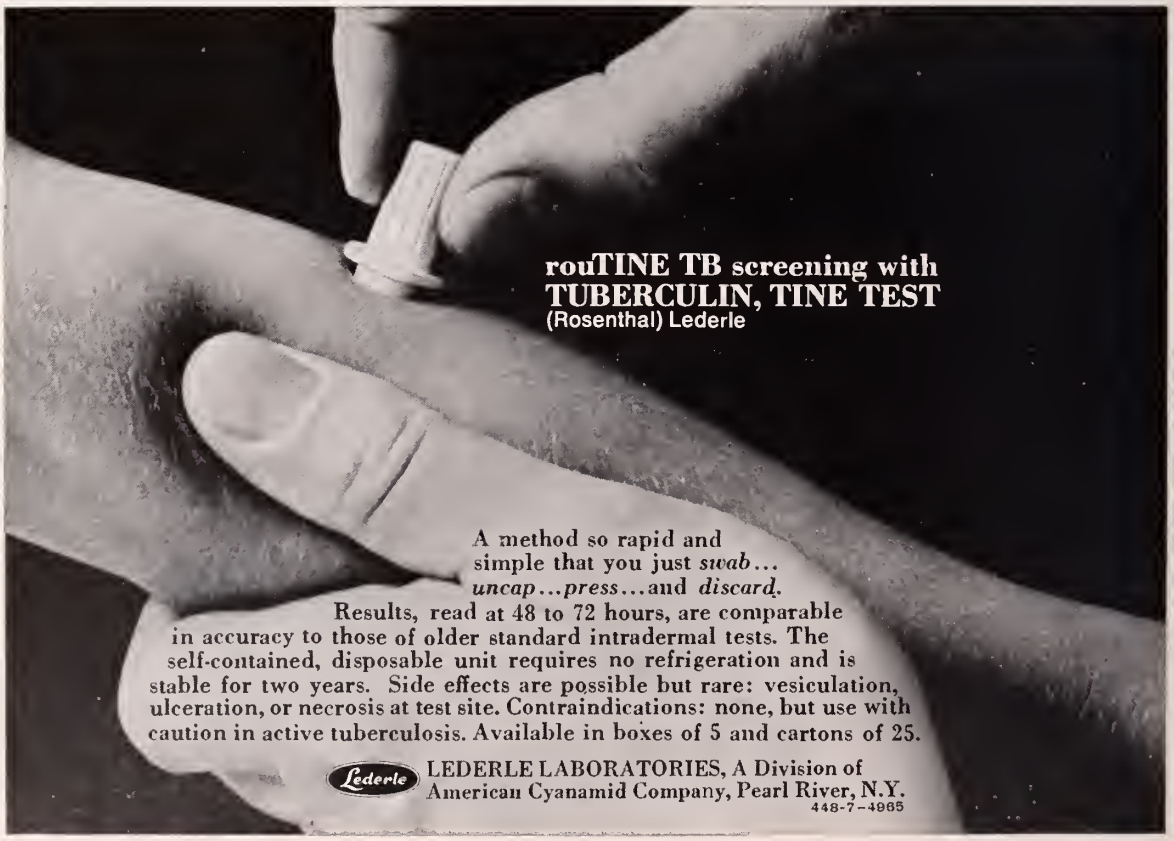
The institute will also feature a dialogue concerning the topic "Is Wisconsin Ready for Prevention Programs." Speakers include *Dr. Leonard Ganser*, Division of Mental Hygiene; Lt. Governor Jack Olson; Mr. George Donahue, originator of Teacher–Mom Program; *Dr. Jack Westman*, University of Wisconsin; Mr. Eli Tash, WAMH board member; Atty. General Bronson LaFollette; Mr. John Melcher, Bureau for Handicapped Children; and *Dr. Darold Treffert*, Superintendent, Winnebago State Hospital.

Pioneering in Comprehensive Mental Health

Crossing state lines with a comprehensive mental health program is only one of the traditional barriers being broken by the newly formed Mental Health Service of Marinette and Menominee, Incorporated and its first executive director, Theodore Ver Haagh. This unique cooperative venture between two states, Michigan and Wisconsin, and two counties, Marinette and Menominee, is the only known program of its kind in the United States, according to Mr. Ver Haagh.

This geographic area is one of the last areas in Wisconsin and Michigan to obtain this type of service. The Clinic is located on the fourth floor of the Marinette General Hospital in Marinette. It has been in operation since May 1.

Two psychiatrists are serving the Clinic: Dr. James F. Caffrey, medical director, and Dr. Clarence Rothe, both residing and practicing in Green Bay.



NEWS OF WISCONSIN PHYSICIANS

Green Bay MD Serves in Vietnam

A Green Bay surgeon is the eighth Wisconsin physician to serve in a civilian hospital under the "Volunteer Physicians for Vietnam" project. The program is administered by the American Medical Association. *Dr. Thomas J. Beno* left in July to spend 60 days treating civilians in a hospital in Can Tho, 80 miles southwest of Saigon on the Mekong river. Doctor Beno has served in Korea, and he has been director of medical-health service for Brown County civil defense since 1961. A Green Bay native, he has practiced in Green Bay since 1957.

Dr. Bloodworth, Jr. Visits Europe

Dr. J. M. B. Bloodworth, Jr., Madison, professor of pathology at the University of Wisconsin, recently visited Europe where he spent some time visiting hospitals in London and also presented a talk at the London Postgraduate Medical School–Hammersmith Hospital. Doctor Bloodworth also went to Stockholm to participate in the International Diabetes Federation meeting.

Dr. Robinhold, III Joins UW Faculty

Dr. Daniel G. Robinhold, III recently was appointed to the University of Wisconsin Medical faculty to do special studies in coronary heart disease activities. Doctor Robinhold comes to Madison under the heart disease program of the U. S. Public Health Service National Center for Chronic Disease Control, Arlington, Va.

Dr. R. R. Liebenow Honored

Dr. R. R. Liebenow, Lake Mills, recently was honored at an open house in Lake Mills. Doctor Liebenow, who was born in Lake Mills, announced his retirement from general practice.

Dr. Albright Joins Marsh Clinic

Dr. John J. Albright, Ajo, Ariz., recently joined the staff of the Marsh Clinic at Shawano. Doctor Albright, a native of Racine, graduated from the University of Wisconsin Medical School and spent his internship in Utah. He was on the staff of the Mendota State Hospital for one year and for the past five years was a general practitioner in Ajo.

Dr. Ritzenthaler Joins Clinic

Dr. David O. Ritzenthaler recently joined the staff of Medical Associates in Beaver Dam. Doctor Ritzenthaler received his degree in medicine from the University of Wisconsin and took his internship at McKennan Hospital, Sioux Falls, S. D. For the past two years, Doctor Ritzenthaler has served in the U. S. Navy.

Dr. Gulyn Joins Guidance Center

Dr. Bohdan E. Gulyn, Wausau, recently joined the Marathon County Guidance Center as psychiatrist on a part-time basis. Doctor Gulyn has also set up a private practice in Wausau. He graduated from the medical school of the University of Vienna, Austria, and had three years of general practice residency and training at City Hospital, Vienna. Doctor Gulyn trained in neuropsychiatry at Rome, N. Y., State School, Gowanda State Hospital, New York, and at the Veterans Administration in westside Chicago, Ill. Since 1960, he has been working in a V. A. neuropsychiatric hospital, Chillicothe, Ohio, and a V. A. center, Dayton, Ohio, where he was assistant chief of psychiatric service. Doctor Gulyn's wife is from Austria and has an M.D. degree with specialty training in anesthesiology.

Dr. Siebecker Assists in Nicaragua

Dr. Karl Siebecker, professor and chairman of the University of Wisconsin Department of Anesthesiology, recently spent three weeks assisting in the polio epidemic in Nicaragua.

Dr. Molina New Associate

Dr. Rodolfo Molina, Beaver Dam, recently became associated with the Consultant Physicians in Pathology in Beaver Dam. Doctor Molina graduated from the University of Santo Tomas, Manila, the Philippines, and completed his residency in pathology at Deaconess Hospital in Milwaukee.

Dr. Witt Joins Clinic

Dr. Darrell Witt, River Falls, recently joined the staff of the River Falls Medical Clinic. Doctor Witt graduated from the University of Iowa and served his internship at a Flint, Mich., hospital. He served in the U. S. Army for five years.

Marshfield Clinic Adds Two to Staff

Dr. Raymond E. Burrill and Dr. Oscar J. Dominguez recently were added to the staff of the Marshfield Clinic. Doctor Burrill will specialize in obstetrics and Doctor Dominguez in plastic surgery.

Doctor Burrill graduated from Stritch College of Medicine, Loyola University, Chicago, and interned and spent three years of residency in obstetrics and gynecology at Akron General Hospital in Akron, Ohio. From 1965 to 1967 he was chief of the obstetrics and gynecology department at the U. S. Air Force base in Minot, N. D.

Doctor Dominguez graduated from the University of Antioquia Medical School in Colombia. After completion of his internship, he worked for two years

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with the Colombia Public Health Service and then studied basic science surgery at the University of Pennsylvania for six months and general surgery for four years at Jackson Memorial Hospital at the University of Miami, in Florida. For the past three years, he has been studying under Dr. Truman Blocker, plastic surgeon at the University of Texas Jones Sealy Hospital in Galveston.

Dr. Cozine Joins Staff

Dr. Winston Irvin Cozine, Kenosha, recently joined the staff as associate pathologist at Kenosha Memorial Hospital. Doctor Cozine had been serving as a pathologist in the U. S. Public Health Services Hospital in New Orleans, La., and had been on the teaching staff of the Tulane University School of Medicine before coming to Kenosha.

Dr. Magnin Opens Practice at Boren Clinic

Dr. Dean Magnin, Pine Beach, recently began a general surgical practice with the Boren Clinic in Marinette. Doctor Magnin graduated from the University of Wisconsin Medical School and interned and did his residency in general surgery at St. Vincent Hospital in Toledo.

Dr. Martin Certified

Dr. John E. Martin, Green Bay, recently was certified by the American Board of Radiology. Doctor Martin received his medical degree from the Marquette University School of Medicine and served his internship at Tripler General Hospital, Honolulu. His residency, in radiology, was spent in Jackson Memorial Hospital, University of Miami, Fla.

Named to MD Examiner Board

Doctors David J. Twohig, Fond du Lac, *Glen S. Custer*, Marshfield, and *John Satory* of La Crosse were recently named to the State Board of Medical Examiners. *Dr. Thomas E. Henney*, Portage, was reappointed by Governor Knowles, who named all four to four-year terms.

Dr. Dougherty Writes Article

Dr. Philip J. Dougherty, Menomonee Falls, recently wrote an article on "The Medical History of Menomonee Falls" which was featured in the Menomonee Falls Diamond Jubilee book. Doctor Dougherty gave a brief summary of the period when the first physician arrived in the Menomonee Falls area in 1839 until the present time when the area has 3 medical clinics, 25 physicians, including 17 specialists, 13 dentists, 5 pharmacies, and its own modern hospital.

Dr. Pinkerton Opens Practice

Dr. John Pinkerton, Menominee, recently opened his practice in Menominee. He has been certified as a specialist by the American Board of Surgery. Doc-

tor Pinkerton graduated from George Washington University at Washington, D. C., interned at Presbyterian–St. Luke Hospital at Chicago, and completed a four-year residency in general surgery at Hines Veterans Hospital. For the past two years, Doctor Pinkerton has been on active duty with the U. S. Navy.

Dr. Murphy Guest Speaker

Dr. P. W. Murphy, Bloomer, recently addressed the members of the Bloomer Kiwanis Club.

Dr. Greist Receives Award

Dr. John H. Greist, Madison, resident in medicine at University Hospitals, recently received the first Award for Distinguished Teaching by a resident at the Medical Center's second annual Intern–Resident Recognition ceremony. Doctor Greist also wrote a paper on "William Osler's Education" which will be published in the WISCONSIN MEDICAL JOURNAL in the near future.

Dr. Thayer Featured in Paper

Dr. Richard Addison Thayer, Beloit, recently was featured as an "Outstanding Beloiter" in the BELOIT DAILY NEWS.

Dr. Goetsch Honored for 55 Years of Service

Dr. O. F. Goetsch, Hustisford, recently was honored at a dinner of the Hustisford Lions Club. Doctor Goetsch, who has been recognized by the State Medical Society for his 50 years of medical practice, has now been practicing medicine in Hustisford for 55 years.

Dr. McMillan New Associate

Dr. Willis G. McMillan, Madison, recently became associated with *Doctors James F. Land, John Kimball Scott*, and *Harold E. Manhart* in the practice of otorhinolaryngology.

Dr. Kief Given State Board Post

Dr. H. J. Kief, Fond du Lac, recently was appointed to the newly created Wisconsin Health and

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[1] Gale, E. T. and Thewlis, M. W., Geriatrics 8:80, 1953
[2] Personal Communication: R. C. Brunner, Pharmaceutical Div., Sunkist Growers

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Social Services Board. *Dr. William Studley*, Shorewood, physician and psychiatrist and long time member of the State Welfare Board, was named acting chairman.

Dr. Thompson Receives Grant

Dr. Wayne H. Thompson, Madison, of the University of Wisconsin preventive medicine department, was awarded a renewable annual stipend of $53,426 to continue the study of California encephalitis virus in Wisconsin. Doctor Thompson heads the Zoonoses Research Laboratory which studies transmission of diseases from animals to man, and has led research on distribution of California encephalitis.

Dr. Barreto Named to Kenosha Memorial Post

Dr. Reinaldo Santiago Barreto recently was appointed to director of the Department of Anesthesiology and Inhalation Therapy at Kenosha Memorial Hospital. Doctor Barreto was formerly an associate professor of anesthesiology at Marquette University.

Dr. Jones Is Cited

Dr. Walter Jones, La Crosse, recently accepted an award honoring him as a distinguished senior alumnus of the University of Pennsylvania. Doctor Jones recently celebrated the 50th anniversary of his graduation from Pennsylvania.

Milwaukee Doctors Help During Rioting

According to James Kelley, executive secretary of The Medical Society of Milwaukee County, doctors were escorted by police into the inner core area of Milwaukee while on emergency calls during the rioting in late July and August. Mr. Kelley stated that many bedridden core residents had been moved to hospitals the first night and following day of the rioting. About 200 doctors slept in 14 area hospitals during the crisis which caused Milwaukee's mayor, Henry Maier, to place a curfew on all residents during the first few days of the outbreak.

Dr. Nelson Appointed to Faculty

Dr. John W. Nelson, formerly chief of the neurology section at the Kennedy Veterans Administration Hospital, Memphis, Tenn., recently was appointed associate professor of neurology at Marquette University School of Medicine, Milwaukee. He is a graduate of Indiana University School of Medicine and received his neurology training at that medical center.

Dr. Good Joins Marquette Faculty

Dr. Thomas A. Good has been named associate professor of pediatrics and is a specialist on metabolic disorders of children at Marquette University School of Medicine, Milwaukee. Doctor Good was associated with the University of Maryland School of Medicine before joining the Marquette faculty.

Marquette University Names Three to Staff

Marquette University School of Medicine recently named three new members to its staff. They are Dr. Madhu Mody, a specialist in cardiology, as assistant professor of pediatrics; *Dr. Carol Ann Haller* as assistant professor of pathology; and Dr. Teruo Masukawa as assistant professor of pathology and assistant professor of gynecology and obstetrics.

Dr. Schneider Joins UW Faculty

Dr. J. Morton Schneider has joined the staff of the University of Wisconsin department of gynecology and obstetrics as an instructor. He received his MD degree from the University of Michigan in 1960.

Dr. Burgoyne Attends Conference

Dr. F. H. Burgoyne, pathologist for the Marshfield Clinic, recently attended the medical technology conference at Wisconsin State University—Eau Claire.

Dr. Opitz Studies Birth Defect Problems

Dr. John M. Opitz, an assistant professor of pediatrics and medical genetics at the University of Wisconsin Medical School, Madison, is attempting to identify certain types of birth defects and their causes and to assess the likelihood of a recurrence in a family's future children. Doctor Opitz is working under a March of Dimes grant which was presented to the Medical School.

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Dr. Ahmed Returns to Pakistan

Dr. Saiffuddin Ahmed, Ogema, recently closed his office in Ogema where he had practiced for the last two years. Doctor Ahmed is returning to Pakistan, his native country. He was a member of physicians' staff at Memorial Hospital of Taylor county.

Resident Doctors Aid Hospital

Two resident doctors from Marquette University School of Medicine, Drs. R. Fred Schelbach, and George Cochran, recently were on duty at Plymouth Hospital for Road America patrons for a weekend.

Dr. Hidde Heart Unit President

Dr. Frederick G. Hidde of Sheboygan was recently elected to a second term as president of the Sheboygan County Unit of the American Cancer Society at its annual meeting July 25 at the Sheboygan Clinic.

Dr. Campbell Joins Project Hope

Dr. Paul E. Campbell, Waukesha, recently joined Project Hope's teaching–treatment mission to Cartagena, Colombia. Doctor Campbell is a graduate of the University of Wisconsin and the University of Pennsylvania Medical School.

Dr. Collentine, Sr. Now a Priest

Ten years after retiring from medical practice, Dr. George Collentine, Sr. is now Father Fidelis who is on an extern program at St. Mary's Hospital, Milwaukee, where he was a former staff physician. Following a three-month training program at St. Mary's Father Fidelis will return to St. Theresa's, a 200-bed Catholic home in New Hope, Minn., which will be completed in October, and assume the position of chaplain and counselor and physician to the residents of the home.

MEDICAL SELF-HELP STATUS REPORT FOR WISCONSIN

The State of Wisconsin ranked seventh in the nation in the number of students reported during June 1967 in the Medical Self-Help Training Program carried on by the Section of Emergency Health Services of the Division of Health, Department of Health and Social Services (formerly the State Board of Health and the State Department of Public Welfare), according to James Joyce, medical self-help consultant to the Section.

The July report again is the largest July since the start of the program. Mr. Joyce indicated that this continuing high level of activity reflects the cooperation of all agencies involved.

The status report, based on instructor report forms received, covers the period March 1963 through July 1967. There were 360 July courses completed; students numbered 10,392. Total courses completed for the entire period: 3,608; students: 143,426.

Demonstrations of a new, low-cost, rescue-breathing training aid, a new universal dressing, and the format of a statewide television promotion on medical self-help training were made at the State Civil Defense Area meetings during August.

Medical Education Expansion Urged by Governor's Task Force

The medical education problem and the doctor-patient ratio in Wisconsin were discussed by the Governor's Medical Education Task Force at a meeting in mid-August when a report was presented by Harry K. Spindler, task force staff director and assistant director of the state coordinating committee for higher education.

The report emphasized that the number of medical students being trained in Wisconsin should be increased and a statewide program of medical education developed.

The recommendations made in the report included the following points:

- The number of first year medical students should be increased to 275 as soon as possible from the current 210, with 125 in Madison and 150 in Milwaukee.
- Long-range planning should provide for an additional development to 300 first year students in 1975 and 350 by 1985. Of these, 150 would be in Madison and 200 in Milwaukee.
- The coordinating committee for higher education should study educational programs with a view toward providing an adequate pool of medical students.
- Efforts should be made to reduce attrition of medical students through "adequate budgetary support" for quality educational programs and by encouraging high caliber students to enter the profession.
- Programs should be developed to help reverse the current number of physicians leaving Wisconsin, and assistance should be available to help physicians settle in the state.
- Internship and residency programs should be expanded around the state.
- The major medical centers should provide leadership and cooperate with selected hospitals used to train doctors.
- Provision must be made to finance medical education costs in hospitals used to train physicians.
- Electronic communications systems, such as closed circuit television, should be developed to link facilities in a statewide medical education network.

"Wisconsin's relative position of today (regarding the number of physicians available) will decline unless positive steps are taken to increase the state's supply of physicians," the report said.

UW FORMS NEW DEPARTMENT OF REHABILITATION MEDICINE

The University of Wisconsin Medical School has formed a new department which will consolidate all research, teaching, and patient care in the area of rehabilitation.

Dr. Peter L. Eichman, Medical School dean, who made the announcement, said that *Dr. Arthur A. Siebens* has been appointed first chairman of the new department of rehabilitation medicine. The appointment was effective July 1.

Doctor Siebens, who also holds appointments as professor of pediatrics and physiology, has been director of the Medical School's rehabilitation center. That center will be absorbed into the new department.

According to Doctor Siebens, the department of rehabilitation medicine affords an efficient means of streamlining the work of many health professions involved in patient rehabilitation.

Initially, Doctor Siebens said, the department's faculty will include representatives from such medical and paramedical specialties as pediatrics, medicine, surgery, neurology, social service, communicative disorders, and nursing.

This faculty, utilizing a team approach to patient care, will have special interest in patients with serious defects, illnesses, or handicaps which may require comprehensive care.

In addition, Doctor Siebens pointed out, research in all fields relating to rehabilitation will be encouraged, and where feasible will be directed by the new department.

Other faculty members of the new department include *Drs. Marc Hansen*, assistant professor of pediatrics; *J. D. Kabler*, associate professor of medicine; *John Pellett*, associate professor of surgery; and *Henry Peters*, associate professor of neurology.

Also included are Drs. *Allan J. Ryan*, associate professor of physical education; Charles Tait, assistant professor of surgery and communicative disorders; *Herman Wirka*, professor of orthopedic surgery; and Stanley Ewanowski, assistant professor of communicative disorders and neurology.

PHYSICIAN NEWS *continued*

Dr. Silverman Joins Clinic

Dr. Carl G. Silverman, Madison, recently joined the staff of the Jackson Clinic in the department of internal medicine. Doctor Silverman graduated from Harvard Medical School and served his internship and one year of residency at Boston City hospital. He served in the United States Public Health Service for two years, and served a three-year residency at University Hospitals of Cleveland.

Dr. Falk Returns to Vietnam

Dr. V. S. Falk of Edgerton left September 22 from San Francisco to return to Vietnam for a two-months tour at a civilian hospital under the "Volunteer Service for Vietnam" project administered by the American Medical Association.

Doctor Falk, who spent two months there last year, expected to return to Vinh Binh in the Mekong Delta. After his 60 days in Vietnam he will meet his wife in Bangkok, Thailand, on Thanksgiving Day. They will visit India, Greece, Spain, and Portugal on their return trip.

Following his first trip to Vietnam, Doctor Falk gave over 40 talks and received about $1500 in contributions for the Vietnamese. From this fund Doctor Falk has sent $300 to the Vinh Binh orphanage (which is as much as the Sisters receive from the government each year). He has sent to the hospital a vacuum extractor (for the midwives to use for deliveries), dozens of crutch tips (for the crutches improvised from bamboo), many surgical instruments and supplies (e.g., 60 surgical scissors, 15 dozen pair of rubber gloves, etc.); and he planned to take a Dermatome with him on this trip. Unfortunately he was unable to supply the commercial laundry that was requested for the hospital.

Late Flash!

Dr. Robert S. Baldwin, retired Marshfield physician and former medical editor of the WISCONSIN MEDICAL JOURNAL, died August 29 at his summer home at Beaver Lake near Hartland. He had been employed by the Florida State Board of Health this past year.

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OBITUARIES

Dr. Norman L. Lindquist, 59, of the finest tradition of family physicians and community leaders, died June 19, 1967, in his home in Escanaba, Mich.

Doctor Lindquist graduated from the University of Wisconsin Medical School in 1933, experienced his internship and residency in surgery at the Milwaukee County General Hospital, then served the upper Peninsula of Michigan for over 30 years, first as general practitioner, then as eye, ear, nose and throat specialist.

Whether it was as president of the Upper Peninsula Medical Society, city recreation board member, Boy Scout commissioner, high school team physician (youth and education were among his keenest avocations), selective service consultant, church elder, parent, or physician and surgeon, he left a legacy of dedication, ethical integrity, honesty, good humor, and appreciation of those he served.

(EDITOR'S NOTE: We are grateful to Mr. John Lindquist for giving us the above information about Doctor Lindquist.)

Dr. Edward A. Loomis, 102, Janesville, died June 25, 1967, in Beloit.

Doctor Loomis was a graduate of the Milwaukee Medical College and was listed in the records of the American Medical Association as one of 21 of the nation's physicians "99 years or over." His professional practice was conducted in Union Grove, Emerald Grove, and Janesville. Doctor Loomis maintained offices in Janesville for over 53 years. He was Janesville's oldest resident.

Surviving are his widow, Myra; two sons, O. E., Rockton, and Quinn J., Janesville; and a daughter, Edna, Janesville.

George S. Kilkenny, 65, Milwaukee, died June 29, 1967, in Milwaukee.

Doctor Kilkenny graduated from the Marquette University School of Medicine in 1931 and took his internship and residency at Milwaukee County Hospital. At the time of his death he was chief of staff of St. Joseph's Hospital. Doctor Kilkenny was a member of the Medical Society of Milwaukee County, State Medical Society of Wisconsin, and American Medical Association. He was formerly a member of the State Medical Society's House of Delegates and a councilor for the 12th district.

Surviving are his widow, Estelle; three daughters, Mrs. Margaret Carmichael of Whitewater, Mary Ellen and Jane M. of Milwaukee; and two sons, James B. and John R. of Milwaukee.

Dr. John W. Connell, 71, a former Fond du Lac physician, died June 27, 1967, in Sheboygan. Doctor Connell was chief radiologist for the US Veterans Hospital, Beckley, West Va., for 15 years until his retirement. He is survived by two sisters, Mrs. Julius Clark, Wauwatosa, and Mrs. Walton Finn of Tucson, Ariz.

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SOCIETY RECORDS

MEMBERSHIP REPORT AS OF AUGUST 2, 1967

NEW MEMBERS

Foreman, John W., 2909 Santa Fe Trail, Racine, 53404
Ihle, Charles V., 27-A University Houses, Madison 53705
Patton, Charles H., 719 Kingston Ave., Racine 53402
Peterson, William G., 1605 Monroe St., Madison 53711
Rafiullah, Mohammed, 3601 Mercury Lane, Racine 53404
Sparks, George M., 6110 Century St., Apt. 209C, Middleton 53562
Stephens, James P., 1715 Rhode Island, Sturgeon Bay 54235
Tuffli, Gordon A., 30 South Henry St., Madison 53703

CHANGES OF ADDRESS

Barreto, R. S. A., Milwaukee, to 6225 Seventh Ave., Kenosha 53140
Belza, Janusz, Palo Alto, Calif., to Box 25, Pebble Beach, Calif.
Berk, Richard A., 3070 N. 79th St., Milwaukee 53222
Blum, Jerome V., Milwaukee, to 1090 Scott Blvd., Santa Clara, Calif. 95050
Bryant, David G., Colorado Springs, Colo., to 4 Kent Lane, Silver Bay, Minn. 55614
Burgarin, N. L., 221 East Washington Ave., Tomahawk 54487
Burke, D. R., 3143 Southwood Dr., Racine 53406
Cherry, James D., Madison, to 1465 S. Grand Blvd., St. Louis, Missouri 63104
Francisco, O. M., 221 East Washington Ave., Tomahawk 54487
Gager, Walter E., Shorewood, to 350 Woodcrest Rd., Key Biscayne, Fla. 33149
Gjud, Alexander M., 4768 South 27th St., Milwaukee 53221
Golden, Peter B., 2228 Hillington Green, Madison 53705
Graber, Rex E., Eau Claire, to 721 West Willow St., Chippewa Falls 54729
Grand, C. A., Masonic Temple Bldg., Ashland 54806
Guillermo, Remedios A., Cleveland, Ohio, to V. A. Center, Wood 53193
Harper, Samuel B., Box 391, Madison 53701
Heinzelmann, Conrad, 811 East Wisconsin Ave., Milwaukee 53202
Jaques, Darrell A., 8708 Magnetic, El Paso, Tex. 79904
Johnson, Kenneth O., 3003 West Goodhope Rd., Milwaukee 53209
Kundel, Robert R., P.O. Box 509, Rice Lake 54868
Leite, Joaquim, Wood, to 3333 Fifth Ave., South Milwaukee 53172
Macksood, John M., Brown Deer, to 3169 West Pierson Rd., Flint, Mich. 48502
Marck, Abraham, Milwaukee to 500 Sherbourne St., Toronto, Canada
Martens, Jacob H., Madison, to 1921 Fairmount St., Wausau 54401
Mauthe, Howard, 74 South Reserve Ave., Fond du Lac 54935
Montenegro, Jose V., 300 East Capitol Dr., Milwaukee 53212
Nolta, Robert T., 2413 Ruger Ave., Janesville 53545
Organick, Avrum B., Milwaukee, to Denver General Hospital, West 6th Ave. at Bannock, Denver, Colo. 80202
Paluska, Donald J., USAFH Tachtkawy, Japan, San Francisco, Calif. 96303
Phillips, Richard L., Milwaukee, to 1775 Dempster Ave., Park Ridge, Ill. 60068
Pitts, Frederick R., Jr., 20 South Park St., Madison 53715
Qui, Felipe L., 1853 Cranston Rd., Apt. 111, Beloit 53511
Russell, William T., 114 Columbus, Sun Prairie 53590
Sadd, John R., Madison, to 4917 Robinhood Lane, Toledo, Ohio
Stebbins, W. W., St. Petersburg, Fla., to 4021 Hiawatha Dr., Madison 53711
Swint, Margery J., Cassopolis, Mich., to 107 Goucher Cr., Oakridge, Tenn. 37830
Tegtmeyer, Gamber F., Jr., 20 South Park St., Madison 53715
Tonkens, S. W., 925 East Wisconsin Ave., Milwaukee 53202
Wegmann, George H., Milwaukee, to 3003 West Good Hope, Glendale 53209
Winnik, Donald E., 221 West Silver Spring Dr., Milwaukee 53217

REMOVED FROM MEMBERSHIP

Gardner, Weston D., Milwaukee County, resigned
Klein, Theodore W., Rock County, resigned
Waddell, John G., Dane County, removed per County Secretary
Wasserburger, R. H., Dane County, removed per County Secretary

DEATHS

Loomis, Edward A., nonmember, June 25, 1967
Scheid, Milo M., nonmember, June 25, 1967
Connell, John W., nonmember, June 27, 1967
Kilkenny, George S., Milwaukee County, June 29, 1967
Guzzo, Harold, Ashland–Bayfield–Iron County, July 12, 1967
Davis, Milton D., Rock County, July 24, 1967

* * *

Society Offers Cooperation to Nicaragua Medical Society

Because Nicaragua has been "adopted" by the State of Wisconsin as its "sister state" through the Alliance for Progress, the Council has expressed its willingness to cooperate in any way possible with the Nicaragua Medical Society in its development of organization and the advancement of the science of medicine for the common good. Dr. Henry Peters of Madison is serving on the Governor's committee handling the Alliance for Progress.

* * *

A TREATMENT CENTER FOR ALCOHOLICS has been established at the Outagamie County Hospital, Appleton, with the cooperation of the courts, the help of Alcoholics Anonymous, and through facilities of staff and programs already in existence at the hospital. Dr. George Lyslof, director of the alcoholic unit at Winnebago State Hospital, is consultant to Outagamie Hospital.

BOOKS RECEIVED

MODERN TREATMENT: Vol. 4, No. 3

Treatment of Kidney Stones, guest editor: Felix O. Kolb, M.D.; and Treatment of Acute Oral Ulcerations: Edward A. Graykowski, M.D., D.D.S.; Hoeber Medical Div., Harper & Row, New York, 1967. Published bimonthly. 1,500 pages annually. Subscription: $16.00 per year.

THE PHYSICIAN'S ROLE IN HIGHWAY SAFETY

By John H. Rosenow, M.D. and Robert W. Watkins; and

THE DOCTOR AT THE SCENE OF THE ACCIDENT

By Claude R. Hitchcock, M.D., reprinted 1967 from Modern Medicine Publications, Inc., 4015 West 65th St., Minneapolis, Minn. 55435.

THE NATURE OF LIFE AND CANCER

By Benedict V. Favata, M.D. and Frank J. Pirone, M.D., Philosophical Library, Inc., New York, N.Y., 1967. 98 pages. Price: $4.75.

DIRECTORY OF ON-GOING RESEARCH IN SMOKING AND HEALTH

U.S. Department of Health, Education, and Welfare, Public Health Service, Bureau of Disease Prevention and Environmental Control, National Center for Chronic Disease Control, National Clearinghouse for Smoking and Health, Arlington, Va. 22203. 228 pages, 1967. Price: $1.25.

INTERVIEW DATA ON CHRONIC CONDITIONS COMPARED WITH INFORMATION DERIVED FROM MEDICAL RECORDS

Vital and Health Statistics, date evaluation and methods research. National Center for Health Statistics—Series 2, No. 23. U.S. Department of Health, Education, and Welfare, Public Health Service, Washington, D.C., May 1967. 84 pages. Price: 85¢.

CASTE AND RACE

Ciba Foundation Symposium, edited by Anthony de Reuck and Julie Knight. Little, Brown & Co., Boston, 1967. 348 pages. Price: $12.

DEVELOPMENT OF THE LUNG

Ciba Foundation Symposium, edited by Anthony de Reuck and Ruth Porter. Little, Brown & Co., Boston, 1967. 408 pages. Price: $13.

ENDOCRINOLOGY OF THE TESTIS

Ciba Foundation Colloquia on Endocrinology, Vol. XVI, edited by G. E. W. Wolstenholme and Maeve O'Connor. Little, Brown & Co., Boston, 1967. 331 pages. Price: $12.50.

THIAMINE DEFICIENCY

Ciba Foundation Study Group No. 28, edited by G. E. W. Wolstenholme and Maeve O'Connor. Little, Brown & Co., Boston, 1967. 163 pages.

RED IS THE COLOR OF HURTING

Planning for Children in the Hospital. Milton F. Shore, Ph.D., editor, Department of Health, Education and Welfare, Superintendent of Documents. U.S. Government Printing Office, Washington, D.C. 20402. 94 pages, 1967. Price: $.55.

RESEARCH HIGHLIGHTS NATIONAL INSTITUTES OF HEALTH, 1966

Items of interest on research studies conducted and supported by the Institutes and Divisions of NIH, Department of Health, Education and Welfare, Superintendent of Documents. U.S. Government Printing Office, Washington, D.C. 20402. 101 pages, 1967. Price: $.35.

BOOKSHELF

New books received are acknowledged in this section. From these books, selections will be made for reviews in the interest of the readers and as space permits. Reviews are written by members of the faculty of the University of Wisconsin Medical School. Books here listed will be available on loan from the Medical Library Service, S.M.I. Building, North Charter Street, Madison, Wisconsin 53706

DIABETES FOR DIABETICS, A Practical Guide

George F. Schmitt, M.D. This book explains the cause and treatment of diabetes, as well as its complications and problems, in simple terms which laymen can understand. The Diabetes Press of America, Inc. 30 S.E. 8th Street, Miami, Florida. 237 pages, 1967. Price: $5.95.

HEALTH CHARACTERISTICS by Geographic Region, Large Metropolitan Areas, and Other Places of Residence—United States—July 1963-June 1965

Vital and Health Statistics, data from the National Health Survey. Series 10, No. 36 of the National Center for Health Statistics, U.S. Department of Health Education, and Welfare, Public Health Service, April 1967. 58 pages. Price: $.40.

INTERNATIONAL COMPARISON OF PERINATAL AND INFANT MORTALITY: The United States and Six West European Countries

Vital and Health Statistics—Analytical Studies. Series #3, No. 6. U.S. Dept. of Health, Education, and Welfare, March 1967. 97 pages. Price: $.70.

THE EFFECTS OF EXTERNAL STIMULI ON REPRODUCTION

Ciba Foundation Study Group No. 26, Little Brown & Company, 1967. 107 pages.

MONGOLISM

Ciba Foundation Study Group No. 25, Little Brown & Company, Boston, 1967. 99 pages.

SUCCESS PLANNING MANUAL

By Alfred Armand Montapert. This manual is designed primarily for personal achievement and to help keep your personal affairs in order. It applies executive methods to increase your worth, in all areas of your life: planning, financial, personal, occupation and business, health, mental, family and home, travel and culture, social, spiritual, and retirement. Prentice–Hall, Inc., Englewood Cliffs, New Jersey, 1967. 245 pages. Price: $6.95.

SCHOLASTIC WORLD ATLAS

American Map Co., Inc. 3 West 61st Street, New York, N.Y. 10023, 1967. 47 pages. Price: 89¢.

DRUGS AND PHARMACY ON STAMPS

By George B. Griffenhagen. American Topical Assoc., 3300 North 50th Street, Milwaukee, Wisconsin 53216 (specify Handbook No. 55), 1967. 96 pages. Price: $5.00.

LABORATORY TESTS IN COMMON USE

By Solomon Garb, M.D., Springer Publishing Company, 200 Park Avenue South, New York, N.Y., 10003, 1967. 192 pages. Price: $2.85.

SEXUAL ABUSE OF CHILDREN

The trauma of sexual abuse discloses family disorganization and problems of adjustment. Protec-

tive services provide the soundest approach for minimizing trauma and enhancing adjustment of child and parent. Material presented by Sol Chaneles, Ph.D. and Donald Brieland, Ph.D. The American Humane Association, P.O. Box 1266, Denver, Colorado 80201, 1967. 24 pages. Price: 35¢.

THREE VIEWS OF HYPERTENSION AND HEART DISEASE

U.S. Dept. of Health, Education, & Welfare, Public Health Service Publication No. 1000-Series 2-No. 22. 44 pages. Price: 35¢.

MODERN TREATMENT, Vol. 4, No. 2

Treatment of Shock, by Leslie A. Kuhn, M.D., and Treatment of Arterial Disorders of the Extremities by David I. Abramson, M.D., Hoeber Medical Division, Harper & Row, Publishers, 49 East 33rd St., New York, New York 10016. 451 pages. Subscription: $16.00 per year.

FRENCH'S INDEX OF DIFFERENTIAL DIAGNOSIS

Edited by Arthur H. Douthwaite, 9th ed. The Williams & Wilkins Co., Baltimore, 2, Md. 1034 pages. Price: $24.00.

GYNECOLOGIC PATHOLOGY

By Frederick T. Kraus, C. V. Mosby Co., 3207 Washington Blvd., St. Louis, Mo. 63103. 504 pages. Price: $18.50.

PREVALENCE OF CHRONIC CONDITIONS AND IMPAIRMENTS Among Residents of Nursing and Personal Care Homes

U.S. Dept. of Health, Education, and Welfare, Series 12, No. 8, July 1967. 36 pages. Price: 30¢.

LEARNING MEDICAL TERMINOLOGY STEP BY STEP

By Clara G. Young and James D. Barger, C. V. Mosby Co., 3207 Washington Blvd., St. Louis, Mo. 63103. 327 pages. Price: $7.50.

BOOK REVIEWS

SYNOPSIS OF EAR, NOSE, AND THROAT DISEASES

By Robert E. Ryan, B.S., M.D., M.S. (ALR), F.A.C.S., William C. Thornell, A.B., B.M., M.D., M.S. (ALR), F.A.C.S., and Hans von Leden, M.D., F.A.C.S., F.I.C.S. 2nd edition. C. V. Mosby Co., St. Louis, Mo. 1963. 425 pages. Price: $7.50.

This book is designed especially as a small handy reference for the family physician, intern, medical student, nurse, and allied paramedical specialties. The contents of the book are divided into easily identifiable sections of ear, nose, paranasal sinuses, pharynx and larynx. Within these four large groups are individual chapters dealing with anatomy, physiology, examination, and the diseases of these particular areas. This logical organization of the sections, coupled with an adequate index makes finding a particular subject quite easy in this book.

Individual sections have been updated from the first edition to reflect current thinking in the management of ENT problems. However, when a particular subject is investigated, it is found that the writing is in such simple form as to be inadequately concise for a medical doctor although it may be quite adequate for paramedical groups. Its strong point is the fact that it is a very short, concisely written book which could be used as a quick review of ENT by medical doctors to give them an overall look at the ear, nose, and throat specialty but more detailed look on management such as Jackson & Jackson published in 1959 would be more adequate as a reference text in the office.

Overall, this book accomplishes its expressed purpose of being a synopsis or overview of the field of ENT but fails as all synopses do to include enough detail to be of much help to the general practitioner.—RAYMOND H. STECKER, M.D.

MANAGEMENT OF THE PATIENT WITH SUBNORMAL VISION

By Gerald Fonda, M.D., F.A.C.S., Associate Clinical Professor of Ophthalmology, New York University School of Medicine; Associate Attending Surgeon. New York Eye and Ear Infirmary. C. V. Mosby Co., St. Louis, Mo. 1965. 161 pages. Price: $11.

This book fills a definite need in ophthalmology for a textbook on a subject where there is no other book. The book is directed to the practicing ophthalmologist. The author's advice is practical for the prescribing of lenses to help the patient with subnormal vision.

The author emphasizes that the average practicing ophthalmologist already has in his possession sufficient equipment to adequately prescribe for the patient with subnormal vision.

This is a book that every practicing ophthalmologist should read and have readily available for his reference.—JAMES C. ALLEN, M.D.

SYMPOSIUM ON CATARACTS

Transactions of the New Orleans Academy of Ophthalmology. By Benjamin F. Boyd, M.D., Professor and Chairman, Department of Ophthalmology, University of Panama School of Medicine; Leonard Christensen, M.D., Associate Professor of Ophthalmology, University of Oregon Medical School, Portland; A. Ray Irvine, Jr., M.D., Medical Director, Estelle Doheny Eye Foundation, Los Angeles; Murray F. McCaslin, M.D., Professor and Chairman, Department of Ophthalmology, University of Pittsburgh School of Medicine; P. Robb McDonald, M.D., Clinical Professor of Ophthalmology, University of Pennsylvania Graduate School of Medicine; John M. McLean, M.D., Head of the Division of Ophthalmology, Cornell University and New York Hospital; Richard C. Troutman, M.D., Professor, Division of Ophthalmology, Department of Surgery, State University of New York, Downstate Medical Center. C. V. Mosby Co., St. Louis. 1965. 340 pages. Price: $19.50.

Seven prominent ophthalmologists have published their discussions which were presented at the New Orleans symposium on cataracts in 1964. They have gone into detail on every aspect of diagnosis and surgical treatment of cataracts.

The authors describe and discuss the various techniques of surgery. Treatment of complications is well covered including the histologic results of complications. There is a new chapter on traumatic and irradiation cataracts.

This book is of interest to every ophthalmologist practicing cataract surgery.—JAMES C. ALLEN, M.D.

CORNEAL CONTACT LENSES

By Members of the Contact Lens Section, Department of Ophthalmology, Baylor University College of Medicine, Houston, Texas. Editor, Louis J. Girard, M.D., F.A.C.S.; Associate Editors, Joseph W. Soper and Whitney G. Sampson, M.D. C. V. Mosby Co., St. Louis, Mo. 1964. 329 pages. Price: $19.75.

This text is by far the most complete and up-to-date reference work available on the design, fabrication, and fitting of corneal contact lenses. It was compiled by Doctor Girard and the members of the contact lens section of the Department of Ophthalmology, Baylor University College of Medicine, in an effort to present to the ophthalmologists a complete and exhaustive instructional and reference work on corneal contact lenses.

Doctor Girard presents a standard nomenclature for the description of the various curves, edges, bevels, etc., of the standard corneal lens, which it is hoped will be adopted as a universal standard by the industry. A short history of the evolution of the corneal lens is presented together with a short but adequate chapter on corneal metabolism and physiology. The optical principles of contact lenses are described in some detail, probably more so than the average ophthalmologist will need. The actual measurement of the surface of the cornea or keratometry is excellently presented, including a new method developed by the authors, of measuring the varying topography of the cornea.

The indications and contraindications for contact lenses, examination of the patient, actual fitting of the lenses, and teaching the patient proper handling, as well as the schedule of wearing time and the follow-up of the contact lens patient, are covered in detail.

The actual construction of the lens and the modification of the lens to fit the individual cornea is covered in great detail, and ideally the ophthalmologist who fits contact lenses should be able to carry out these modifications himself. However practically speaking, the time is seldom available to the busy ophthalmologist. Many of these modifications must be relegated to a contact lens technician, or the lenses must be returned to the fabricator for the necessary modifications. This reviewer is in complete agreement with the authors, however, that the ophthalmologist who accepts responsibility for contact lens patients should have a thorough knowledge of the fabrication and modification of the lenses. He should be able to perform these modifications himself if necessary, thus enabling him to properly supervise the work of a technician and be certain that any necessary changes in the lenses are properly made.

One chapter is devoted to the relationship between the ophthalmologist and contact lens technician, stressing the need for some sort of standardized training and certification of contact lens technicians; a need which this reviewer feels cannot be overly stressed. The final chapter is devoted to special types of lenses and fitting techniques and adequately covers the fitting of the rare, more complicated cases with unusual types of lenses.

Although primarily designed for the ophthalmologist, this text will be found useful by opticians, technicians, optometrists, and others who have taken it upon themselves to accept the responsibility of placing contact lenses on the delicate tissue of the cornea.—FREDERICK J. DAVIS, M.D.

HANDBOOK OF ORTHOPEDIC SURGERY

By Alfred Rives Shands, Jr., B.A., M.D., F.A.C.S., Richard Beverly Raney, B.A., M.D., F.A.C.S., H. Robert Brashaer, B.A., M.D., F.A.C.S. 6th edition. C. V. Mosby Co., St. Louis, Mo. 1963. 591 pages. Price: $11.50.

This book continues to rank high in the expanding library of books on general orthopedic surgery. It was conceived as a concise manual for the medical student and general practitioner and has undergone numerous revisions to keep its contents current.

The format remains the same as earlier editions: The book is divided into 24 chapters, of which 16 bear upon orthopedic conditions on an etiologic basis and 8 on disorders by anatomic regions. The authors have succeeded in arranging the subject matter to accommodate a 24, one hour weekly schedule, which is the period generally apportioned to orthopedic surgery.

The material is well presented and unopinionated and thus retains its value as a textbook for the student of medicine and the paramedical sciences closely related to orthopedic surgery. The bibliography and illustrations are first rate.—HENRY I. OKAGAKI, M.D.

BONE TUMORS

By Louis Lichtenstein, M.D., Clinical Professor of Pathology, University of California, San Francisco; Professor Extraordinario, National University of Mexico; Consultant, City of Hope Medical Center; Consultant in Pathology for three hospitals: Los Angeles County Hospital, Children's Hospital, San Francisco, and Orthopedic Department of St. Joseph's Hospital, San Francisco. Third edition. C. V. Mosby Co., St. Louis. 1965. 411 pages. Price: $16.75.

The accurate recognition of tumors of bone and related tissues has always been a difficult problem for the pathologist and physician. Even after diagnosis there often remains an uneasy sense that there may be malignancy in many lesions of bone.

In this book the author gives us a superbly written discussion beginning with the management of lesions of bone suspected of being tumors and their roentgenographic characteristics. In 22 concise chapters he outlines the various tumors, diagnostic features, and treatment.

There is an easy conversational quality to the writing which remains at the same time quite didactic so that the book is singularly readable and eminently useful to the student of orthopedic surgery and the practicing physician. The illustrations are numerous and well done.—HENRY I. OKAGAKI, M.D.

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Contraindications: Edema; danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia. The drug should not be given when the patient is senile or when other potent drugs are given concurrently. Large doses of Butazolidin alka are contraindicated in glaucoma.

Warning: If coumarin-type anticoagulants are given simultaneously, watch for excessive increase in prothrombin time. Instances of severe bleeding have occurred. Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea, sulfonamide-type agents and insulin. Carefully observe patients receiving such therapy. Use with great caution in the first trimester of pregnancy.

Precautions: Before prescribing, carefully select patients, av in those responsive to routine measures as well as contraindicate pa tients. Obtain a detailed history and a complete physical and labo or examination, including a blood count. The patient should not e ee recommended dosage, should be closely supervised and shou be warned to discontinue the drug and report immediately if fever or throat, or mouth lesions (symptoms of blood dyscrasia); sudden gh gain (water retention); skin reactions; black or tarry stools or he evidence of intestinal hemorrhage occur. Make regular blood c nts Discontinue the drug immediately and institute countermeasures th white count changes significantly, granulocytes decrease, or imr ure forms appear. Use greater care in the elderly and in hyperte es

Adverse Reactions: The most common are nausea, edema an rug rash. Swelling of the ankles or face may be minimized by withh ing dietary salt, reduction in dosage or use of diuretics. In elderly p nts and in those with hypertension the drug should be discontinue wh the appearance of edema. The drug has been associated with pe ul-

the wisconsin medical journal

Official Publication of THE STATE MEDICAL SOCIETY OF WISCONSIN

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MEDICAL MEETINGS

POSTGRADUATE COURSES

1967 WISCONSIN

Nov. 1–2: Wisconsin Heart Association course in "Clinical Cardiology," at Holiday Inn No. 2, Madison.

Nov. 2–3: Conferences in Geriatric and Psychiatric Nursing, University Extension, Madison.

Nov. 4: Seminar on "The Doctor's Assistant Tomorrow," Marshfield Clinic Foundation, St. Joseph's Hospital, Marshfield.

Nov. 6–17: Advanced Maternity Program in Delivery Room Nursing for graduate nurses, Marquette University College of Nursing, Milwaukee.

Nov. 7: Dearholt Lecture, UW, Madison.

Nov. 8: Dearholt Lecture, Marquette, Milwaukee County General Hospital, Milwaukee.

Nov. 8–9: Wisconsin Welfare Council conference, Pfister Hotel, Milwaukee.

Nov. 9: Conference for Nursing Home Nurses, University Extension, Milwaukee.

Nov. 9–10: Milwaukee Medical Conference, sponsored by The Medical Society of Milwaukee County, County Hospital, Milwaukee.

Nov. 10: Conference for Nursing Home Nurses, University Extension, Wausau.

Nov. 10–12: Fall meeting, Wisconsin Society of Pathologists (jointly with Wisconsin Association of Medical Technologists), Milwaukee.

Nov. 13–14: Quackery conference, sponsored by State Medical Society of Wisconsin, Milwaukee Auditorium.

Nov. 16: State School Health Council, Wisconsin Center, Madison.

Nov. 17: Medical-Legal-Industrial Symposium on "Pulmonary Diseases in Industry," sponsored by Mount Sinai Hospital, at Pfister Hotel, Milwaukee.

Dec. 6: UW "In-Depth" postgraduate teaching program, Madison.

1968 WISCONSIN

Jan. 15–26: Advanced Maternity Program in Delivery Room Nursing for graduate nurses, Marquette University College of Nursing, Milwaukee.

Jan. 18: UW "In-Depth" postgraduate teaching program, Madison.
Chicago

Feb. 7–8: "Modern Separation Methods of Macromolecules and Particles," University of Wisconsin, Madison.

Feb. 12–23: Advanced Maternity Program in Delivery Room Nursing for graduate nurses, Marquette University College of Nursing, Milwaukee.

Feb. 21: UW "In-Depth" postgraduate teaching program, Madison.

Mar. 4: Postgraduate course, "Hypoglycemias in Infants and Children," sponsored by Marquette University at Children's Hospital, Milwaukee.

Mar. 11: Postgraduate course, "Etiology and Management of Nephrosis in Children," sponsored by Marquette University at Children's Hospital, Milwaukee.

Mar. 11–22: Advanced Maternity Program in Delivery Room Nursing for graduate nurses, Marquette University College of Nursing, Milwaukee.

Mar. 18: Postgraduate course, "Prevention of Mental Retardation," sponsored by Marquette University at Children's Hospital, Milwaukee.

Mar. 21: UW "In-Depth" postgraduate teaching program, Madison.

Mar. 25: Postgraduate course, "Emotional Crises Among Adolescents," sponsored by Marquette University, Milwaukee.

Mar. 27–28: Sports Medicine and General Medicine, University of Wisconsin, Madison.

Apr. 4–5: Wisconsin Anti-Tuberculosis annual meeting, Milwaukee.

Apr. 4–6: Fetus and Newborn, University of Wisconsin, Madison.

Apr. 18–19: Conference for Directors of Nursing in Small Hospitals, University Extension, Marshfield.

Apr. 22–May 3: Advanced Maternity Program in Delivery Room Nursing for graduate nurses, Marquette University College of Nursing, Milwaukee.

May 9–10: Conference for Directors of Nursing in Small Hospitals, University Extension, Madison.

May 14–16: Annual meeting, State Medical Society of Wisconsin, Milwaukee.

June 8: Semi-annual meeting, Wisconsin Society of Pathologists, University Hospitals, Madison.

1967 NEIGHBORING STATES

Nov. 6–8: First of two identical sessions—Clinical Reviews, Mayo Clinic and Foundation, Rochester, Minn.

Nov. 6–9: Annual scientific assembly, Interstate Postgraduate Medical Association, Palmer House, Chicago

Nov. 8: "Frontiers in Medicine" series—Clinical Allergy and Immunology, The University of Chicago Hospitals and Clinics, Chicago.

Nov. 13–15: Second of two identical sessions—Clinical Reviews, Mayo Clinic and Foundation, Rochester, Minn.

Dec. 13: "Frontiers in Medicine" series—Shock, The University of Chicago Hospitals and Clinics, Chicago

1968 NEIGHBORING STATES

Jan. 19–20: Course in "New Concepts in Problems of Completed Stroke," Kenny Rehabilitation Institute, Minneapolis Minn.

Mar. 7–8: Institute of Medicine of Chicago Workshop —The Doctor and His Hospital, Pick-Congress Hotel.

1967 OTHERS

November: Association of State and Territorial Health Officers, Washington, D. C.

Nov. 16–19: Annual convention, National Society for Crippled Children and Adults, Century Plaza Hotel, Los Angeles, Calif.

Nov. 25–26: American College of Chest Physicians Interim Clinical Meeting, Warwick Hotel, Houston, Tex.

Nov. 26: Ninth national conference on the medical aspects of sports, in conjunction with the annual clinical convention of the American Medical Association, Nov. 26–29, Houston, Tex.

1968 OTHERS

Jan. 10–12: Program on "Current Concepts in Cardiology," Institute for Cardiovascular Diseases, Good Samaritan Hospital, Phoenix, Ariz.

Jan. 14–18: Second annual meeting of the Society of Cryo-Ophthalmology, Miami Beach, Fla.

Feb. 19–21: First of three 1968 sectional meetings in Dallas, Tex., of the American College of Surgeons.

May 4–9: Annual teaching seminar, International Academy of Proctology, Montreux-Palace Hotel, Montreux, Switzerland.

May 13–17: Annual meeting, Ohio State Medical Association, Cincinnati, the Netherland Hilton Hotel.

Sept. 18–20: Sixth National Cancer Conference, Denver Hilton Hotel, Colo.

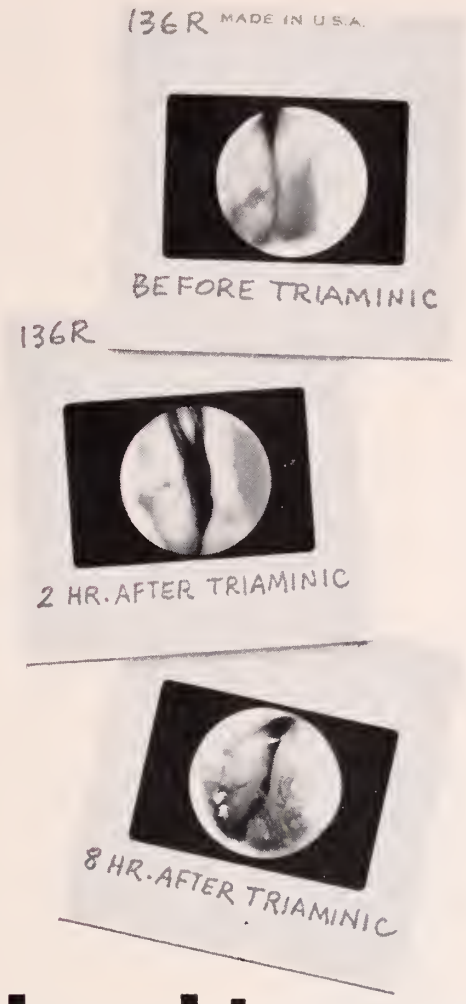
Oct. 21–25: Annual Clinical Congress, American College of Surgeons, Atlantic City, N.J.

1967 AMA

Nov. 26–29: Clinical convention, Astro Hall of Astrodome complex and Shamrock-Hilton Hotel, Houston, Tex.

For listing of other meetings see the JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION.

From a continuing study on nasal congestion . . .



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MEDICAL MEETINGS *continued*

Pulmonary Function Course

The 1967 Fourth Annual Postgraduate Course on Pulmonary Function in Health & Disease to be held in New Orleans, La., will take place Monday, Dec. 4, through Thursday, Dec. 7, at Louisiana State University School of Medicine.

Tuition for the Course is $100 for all physicians. Members of the American Thoracic Society receive a $25 discount. Interested nurses and technicians' tuition is $25. The Course is limited to 150, and application for registration should be made through the Louisiana Thoracic Society, 305 Baronne Street, New Orleans, Louisiana, 70112; Attention: Findley Raymond, Course Coordinator.

The Course will include The Mechanics of Breathing, Clinical Spirometry, Alveolar Ventilation, Distribution of Gases, Office Pulmonary Function Testing, Pulmonary Diffusion, Ventilation–Perfusion Relationships, Pulmonary Function in Children, Cor Pulmonale–Circulation, Acid-Base Problems, and Case Presentations and Demonstrations.

Allergy Course in Denver

The University of Colorado School of Medicine announces a postgraduate course on MODERN CONCEPTS OF ALLERGY, to be presented Dec. 6 through 8 in Denver.

This three-day course is designed to provide assistance to practicing physicians in the recognition and management of the common antigens which have allergic components. It is a patient-oriented conference with emphasis on everyday problems. There will be ample opportunity for registrants to participate in question and answer sessions. Two eminent guest speakers will participate: Ernest M. Heimlich, M.D., Los Angeles, California; and Francis L. Lederer, M.D., Chicago, Illinois. Registration and tuition fees are $60.00.

For further information and a detailed program, write to: The Office of Postgraduate Medical Education, University of Colorado School of Medicine, 4200 East Ninth Avenue, Denver, Colo. 80220.

Fractures and Joint Injuries Course

The University of Colorado School of Medicine announces a postgraduate course on FRACTURES AND JOINT INJURIES, to be presented in Denver Nov. 1 through 3.

This three-day course provides a systematic consideration of fractures and injuries to joints. Registrants are invited to bring with them roentgenograms of their difficult and interesting fracture problems for presentation and discussion by the instructional staff. Two eminent guest speakers will participate: Alonzo J. Neufeld, M.D., Los Angeles, California; and Marcus J. Stewart, M.D., Memphis, Tennessee. Registration and tuition fees are $50.00.

For further information and a detailed program, write to: The Office of Postgraduate Medical Edu-

cation, University of Colorado School of Medicine, 4200 East Ninth Avenue, Denver, Colo. 80220.

Surgeons' Meeting, Las Vegas

The International College of Surgeons' Western Regional Meeting, sponsored by the Southern California Division, will be held Nov. 19 through 22 at the Flamingo Hotel in Las Vegas, Nev.

Topics will range from "Contraception" to "A New Look at the 'One-Day Hernia' and a Differential Epidural Block for Recurrent Inguinal Hernia Surgery" on to include others like Knife and Gunshot Wounds and "The Experiences of a Visiting Professor in Europe."

Captain Paul Engle, Commanding Officer of the Naval Hospital at Long Beach, Calif., will present a lecture entitled, "The Role of the Hospital Ship as Medical Support in the Vietnam Conflict."

Another distinguished participant will be Dr. Edward Compere, President of the International College of Surgeons. Because Thanksgiving Day is Thursday, Nov. 23, the scientific presentations will begin at 9 a.m. Monday, Nov. 20 and will finish at noon Nov. 22. For further information contact the Southern California Division, 321 North Larchmont Boulevard, Los Angeles, Calif. 90004.

Society for Cryo–Ophthalmology, Florida

Society for Cryo–Ophthalmology, Miami Beach, Florida, January 14 to 18, 1968, Statler Hilton Plaza Hotel. The society which was founded to keep ophthalmologists informed of the latest advances in ophthalmic cryosurgery will feature the outstanding cryosurgeons from Europe, South America, and the United States. Dr. Jose Barraquer from Bogota, Colombia, president, will speak on keratophakia, and Dr. Giambattista Bietti from Rome, Italy, president-elect, will lead the discussion on retinal detachment.

Participating on the subject of retinal detachment will be Drs. Dohrmann Pischel, I. D. Okamura, Harvey Lincoff, David Sudarsky, and others. Leading the discussion on cryoextraction of cataracts will be Dr. H. Fanta and Dr. Louis Girard. Other subjects to be discussed include the application of cryogenic technics in the therapy of herpetic keratitis, epithelial downgrowth, glaucoma, pterygium, trachoma, vernal conjunctivitis, and tumors. Drs. H. Kaufman, M. Martinez, and D. Paton will speak on the newly improved freezing methods for preserving the cornea.

Registration: $20.00; $35.00 after January 12, 1968.

Contact: Dr. John Bellows, Secretary, 30 North Michigan Avenue, Chicago, Ill. 60602.

International Academy of Proctology

The 20th Annual Teaching Seminar of the International Academy of Proctology will be a true International Congress in Montreux, Switzerland, May 4 through May 9, 1968. Eminent speakers from Europe, Asia, and the United States will present the latest diagnostic and therapeutic techniques in proctology.

Departing from New York, via Swissair, on Friday, May 3, the group will arrive in Geneva, Switzerland on Saturday, May 4. Special buses will transport the party to the fabulous Montreux–Palace Hotel, Montreux, Switzerland, where first class accommodations will be provided.

Scientific sessions will be limited to mornings and afternoons, Monday through Thursday, leaving the evenings free for dramatic and thrilling excursions; dinners in typical Swiss settings, such as a mountaintop Inn, and old Winecellar, and a Medieval Castle. A boat trip is planned to visit the famous Casino at Evian les Bains in France; and a visit to the famous 9,000 foot, three-stage cabin ski lift at the Diablerets; as well as a visit to the City of Geneva are planned.

For those wishing to do so, extended trips to Italy, France, and England—or other countries—may be arranged. Contact the Executive Officer, 147—41 Sanford Ave., Flushing, N. Y. 11355.

Medical Aspects of Sports Conference

The team physician and the practitioner who has athletes among his patients should find many topics of interest at the 9th National Conference on the Medical Aspects of Sports in Houston, Tex., Sunday, Nov. 26.

Clinical problems in athletics, sports cardiology, knee injuries, the 1968 Olympics at Mexico City, and specialized sports will be topics of forums and discussions.

Morning, afternoon, and evening sessions will be at the Hotel America. Sponsored by the American Medical Association's Committee on the Medical Aspects of Sports, the annual conference is held in conjunction with the AMA's 21st annual Clinical Convention, Nov. 26–29 in Houston.

Speakers will include physicians experienced in sports medicine and other widely recognized sports authorities. Those attending will have opportunities after each session to discuss special problems with the speakers.

Featured speaker at the conference luncheon will be Eduardo Hay, M.D., Mexico City, director general of the Centro Deportivo Olimpico Mexicano, who will discuss preparations for the 1968 Olympic Games.

A session later in the day will discuss the U. S. Olympic athlete. Speakers will include the U. S. Olympic team physician, Daniel F. Hanley, M.D., of Brunswick, Maine; the U. S. Olympic vice president Merritt H. Stiles, M.D., of Spokane, Wash., and the executive secretary of the National Athletic Trainers Association, William E. Newell, R.P.T., Lafayette, Ind.

Some program highlights:

The problem of gastroenteritis is both significant and perplexing to athletes who need to be in top shape daily, at home and on the road. Clayton L. Thomas, M.D., of Wilbraham, Mass., member of

the U. S. Olympic Committee's Medical and Trainers Services Committee, will discuss measures that can be taken to minimize this threat.

The relationship of cardiac problems to athletic participation will be discussed by Kenneth D. Rose, M.D., director of research at the University of Nebraska Health Service, Lincoln. Dr. Rose has done research in medical telemetry, and will discuss how the heart actually responds during exercise, as disclosed by telemetric readings.

Nutrition's role in enabling maximum physical performance will be the topic of the Army's authority on the subject, C. Frank Consolazio, head of the Bioenergetics Division of the Army's medical research and nutrition laboratories at Denver.

"Foolishness and Folklore in Sports" will be the topic of Fred L. Allman, Jr., M.D., of Atlanta, president of the American College of Sports Medicine and orthopedic consultant for University of Georgia varsity teams.

Joining Doctor Allman in a forum on Quackery in Sports will be William M. Fowler, Jr., M.D., of Los Angeles, who will discuss the reasons for condemning use of various drugs known to be used by some healthy athletes.

The physician who many give credit for converting "weight lifting" to "weight training" as a beneficial program for physical education and rehabilitation and for preventing athletic injuries will outline his training principles. Thomas L. DeLorme, M.D., Boston, Mass., will be a participant in one of two forums on clinical problems in athletics.

Richard C. Schneider, M.D., neurosurgical consultant to the University of Michigan athletic department, Ann Arbor, will discuss the medical considerations of returning an athlete to competition following a concussion.

Other speakers in the forums on clinical problems will be Frank L. Raney, Jr., M.D., of San Francisco, who will speak on rib injuries; Robert E. Anderson, M.D., of Ann Arbor, Mich., who will report his findings on genito–urinary injuries, as related to sports participation; and Donald J. Erickson, M.D., of the Mayo Clinic, Rochester, Minn. Doctor Erickson will discuss the practicality and proper use of various injury–treatment devices in the athletic setting.

Three afternoon discussion sessions will be on the Olympics and the American Athlete, Specialized Sports (sports parachuting, equestrian sports, and sports judo), and Sports Cardiology.

An evening forum will discuss prevention of knee injuries in sports. Participants will include H. Royer Collins, M.D., of Temple, Texas; Jay A. Bender, Ph.D., of Cortland, N. Y., and Joe W. King, M.D., of Houston.

The conference is open to interested physicians and key nonmedical athletic personnel.

For further information, write the Committee on the Medical Aspects of Sports, American Medical Association, 535 N. Dearborn St., Chicago, Ill., 60610.

University of Chicago Meetings

The third annual "Frontiers of Medicine" series for practicing physicians will be presented at The University of Chicago Hospitals and Clinics beginning October 11.

Individual programs in the series will be presented the second Wednesday of each month through May 1968.

The programs will be presented mainly by the clinical faculty of The University of Chicago School of Medicine. Guest lecturers from neighboring institutions will take part in several programs. (Dr. A. R. Curreri, professor of surgery, UW Medical Center, Madison, will participate in the March 13 program on "Management of Inoperable Cancer.")

The series is designed to give physicians who have been in practice for several years a comprehensive view of recent developments in various areas of medicine. Particular attention is given to clinical applications. The series is accredited for 24 prescribed hours by the American Academy of General Practice.

All sessions will begin at 2 p.m. in room P-117, Billings Hospital, 950 East 59th Street, Chicago.

The series is presented by the University's Committee on Continuing Medical Education, under the chairmanship of Dr. Joseph B. Kirsner, Professor of Medicine and Chief of the Section of Gastroenterology.

Individual programs and dates are scheduled as follows:

Oct. 11, 1967: Diabetes Mellitus, Common Gynecological Problems
Nov. 8, 1967: Clinical Allergy and Immunology
Dec. 13, 1967: Shock
Jan. 10, 1968: Mental Retardation—Modern Approaches
Feb. 14, 1968: Some New Views in Dermatology
Mar. 13, 1968: Management of Inoperable Cancer
Apr. 10, 1968: Treatment of Cardiac Emergencies
May 8, 1968: Eye Disease—Where Do We Stand?

Further details on the programs and information on registration are available from David M. G. Huntington, Administrative Coordinator, Committee on Continuing Medical Education, The University of Chicago, 950 East 59th Street, Chicago (MUseum 4–6100, extension 5272).

Expanded AMA Postgraduate Education Program

Physicians will have an opportunity to continue their postgraduate medical education at courses offered during the American Medical Association's Clinical Convention in Houston, Tex., Nov. 26–29.

The postgraduate program, expanded to four subjects this year, offers courses in "Fluid and Electrolyte Balance," "Oncology," "Cardiovascular Disease," and "Obstetrics and Gynecology."

Leading medical educators will lecture at the courses, which will consist of three half-day sessions each.

The courses will be limited to 200 persons each; the first 200 who register on arrival in Houston will be given tickets. There will be a special Postgraduate Course registration booth adjacent to the general registration area in Astro Hall.

Courses will begin promptly at 9 a.m. and 2 p.m.

Milwaukee Medical Conference

"Frontiers in Medicine—'67"—the seventh annual Milwaukee Medical Conference for physicians—will be presented at the Coffey Memorial Auditorium, Milwaukee County General Hospital, Thursday, Nov. 9, and Friday, Nov. 10.

The Conference is sponsored by The Medical Society of Milwaukee County in cooperation with Marquette University School of Medicine and its teaching hospitals and has the financial support of the State Medical Society's Charitable, Educational and Scientific Foundation, Marquette University School of Medicine Alumni Association, Milwaukee County General Hospital Intern–Resident Association, Milwaukee Division of American Cancer Society, and the Wisconsin Heart Association.

The program is accepted for 11 hours of elective credit by the American Academy of General Practice. The meeting is open to all physicians and medical students. There is no registration fee.

Program Chairman is Dr. Donald A. Roth, Assistant Professor of Medicine, Marquette University School of Medicine and Wood Veterans Administration Hospital, Milwaukee.

Guest speakers include:

Marion C. Anderson, M.D., Associate Professor of Surgery, Northwestern University Medical School, Chicago, Illinois;

S. Gilbert Blount, Jr., M.D., Professor of Medicine and Head, Division of Cardiology, University of Colorado Medical Center, Denver, Colorado;

Walter Lawrence, Jr., M.D., Professor and Chairman, Division of Surgical Oncology, Medical College of Virginia, Richmond, Virginia;

James W. Linman, M.D., Associate Professor of Medicine, Mayo Graduate School of Medicine (University of Minnesota), Rochester, Minnesota;

Dwight C. McGoon, M.D., Associate Professor of Surgery, Mayo Graduate School (University of Minnesota), Rochester, Minnesota;

Vincent J. O'Conor, M.D., Associate Professor of Urology, Northwestern University School of Medicine, Chicago, Illinois;

Harold P. Roth, M.D., Associate Professor of Medicine, Western Reserve University Medical School; and

David R. Rovner, M.D., Associate Professor, Department of Internal Medicine, Division of Endocrinology and Metabolism, University of Michigan Medical Center.

Subjects to be covered during the two-day scientific program include hypertension, malignant melanoma, anemia, heart disease, pancreatitis, and ulcer disease.

Cardiovascular and surgical clinical rounds with guest faculty will be conducted on Friday morning.

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In addition to the scientific meeting, a Wine Tasting Party has been planned for Thursday evening, Nov. 9, in the Milwaukee Public Museum's "Street in Old Milwaukee" area. Attendance will be by ticket only. Physicians and their wives are invited to attend the gourmet breakfast on Thursday and Friday mornings at the Ramada–Sands Inn at 11811 West Bluemound Road, convention hotel headquarters, and the ladies are invited to a tour of the Mayfair Shopping Center.

A complete program appears elsewhere in this issue.

Further details on the program and information on registration are available from the Public Relations Department, The Medical Society of Milwaukee County, 756 N. Milwaukee St., Milwaukee, Wisconsin 53202 (Area Code 414 273–7700, extension 219).

International Congress of Hygiene

The Fifth International Congress of Hygiene and Preventive Medicine will be held in Rome, Italy, from Oct. 8–11, 1968. Many eminent speakers from different countries have already assured their participation. This Congress will provide an opportunity for representatives of government departments, state and provincial health departments, municipalities, universities, and scientific societies from all parts of the world, as well as those people engaged in the many fields of Preventive Medicine, to meet and discuss problems of common interest.

Registration fees: Active members, $30; associated members, $20. Preliminary registration can be made now with: Segreteria Del V Congresso Internazionale Di Igiene E Medicina Preventiva—Via Filippo Civinini 37—Roma (Italy). Final registration must reach the Secretary's Office by June 30, 1968.

Pan-Pacific Surgical Association

The Eleventh Congress of the Pan-Pacific Surgical Association will be held Oct. 14–22, 1969 (following the meeting of the American College of Surgeons in San Francisco, Calif., Oct. 6–10, 1969) in Honolulu, Hawaii.

The scientific program will consist of some 300 speakers in all surgical specialties. Concurrent meetings will be held in colon and anorectal surgery, general surgery, neurosurgery, obstetrics and gynecology, ophthalmology, orthopedics, otolaryngology, plastic surgery, thoracic–cardiovascular surgery, and urology. Included in the program will be meetings in anesthesiology and radiology.

All scientific meetings will be held in the morning, leaving afternoons free for sightseeing and social events.

General Practice Review, Colorado

The Office of Postgraduate Medical Education, University of Colorado School of Medicine, will present a course on "General Practice Review" Jan. 14–20, 1968, in Denver. A full week of important areas of practice has been arranged as follows: Sunday—Iatrogenic Illness: A Problem of Medical Progress; Monday—Medicine; Tuesday—Pediatrics; Wednesday—Dermatology; Thursday—Surgery; Friday—Obstetrics and Gynecology; and Saturday—Trauma.

For further information: Office of PG Medical Education, UC School of Medicine, 4200 East Ninth Avenue, Denver, Colo.

Medical Genetics Course, Michigan

The American College of Physicians will present a course on Medical Genetics, Nov. 27–30 at the University of Michigan Medical School, Ann Arbor.

This four-day course will consist of a daily series of four or five formal presentations, followed by "work shops" in which the participants are broken up into groups according to their interests. The lectures are designed to be intelligible to those with very little background in genetics, but yet it is proposed to include advanced concepts as well. Especially, attention will be directed toward the many newly recognized inherited biochemical variations in man.

Recent advances in such diverse areas as the hereditary syndromes, the hemolytic anemias, cytogenetics, population genetics, and applications of computers will be touched upon.

Fees: ACP members, $60; nonmembers, $100. Registrations, request for information, and applications to: Edward C. Rosenow, Jr., M.D., Executive Director, ACP, 4200 Pine St., Philadelphia, Pa. 19104.

UW "In-Depth" Programs

A new series of one-day "in-depth" teaching programs for 1967–1968 season has been arranged by the University of Wisconsin Medical School in cooperation with the State Medical Society of Wisconsin and the Madison Chapter of the Wisconsin Academy of General Practice. As in previous programs the meetings consist of morning sessions in Room 300 at University Hospitals, with patients presented for discussion, followed by luncheon, and an afternoon session at the State Medical Society headquarters.

Dates and topics are:

Dec. 6 (Wed): *Marriage on the Rocks*
Jan. 18 (Thur): *Clinical Immunology and Allergy*
Feb. 21 (Wed): *Hypertension*
Mar. 21 (Thur): *Anticoagulants*

There is a registration fee of $5.00 per program, or $20.00 for all four, tax deductible, as the programs are presented through the Charitable, Educational and Scientific Foundation of the State Medical Society. Brochures containing further information and registration forms will be mailed soon.

NEWS OF WISCONSIN PHYSICIANS

Dr. Pfeifer Retires

Dr. F. J. Pfeifer, New London, recently retired from his practice of more than 58 years. Doctor Pfeifer has delivered about 5,000 babies as well as performed all of the many services a small city doctor is called upon to do. He also served as health officer for many years.

Dr. Houfek Aids West Indians

Dr. Edward E. Houfek, Sheboygan, recently spent five weeks on the West Indian leeward islands of St. Kitts and Nevis, east of Puerto Rico. He volunteered his professional services at an invitation of a privately endowed organization, United States–Caribbean Aid to Mental Health, Inc. Doctor Houfek also spoke before the St. Kitts branch of the British Medical Association and worked closely with Dr. Arthur Lake, president of the British Medical and Mental Health Associations.

Dr. Wagner Named Chief of Medicine

Dr. Raymond F. Wagner, Oshkosh, recently was named chief of medicine on the staff of Mercy Hospital in Oshkosh. He is also a member of the Mercy medical staff's executive committee.

Dr. Samp Guest Speaker

Dr. Robert J. Samp, Madison, recently was the guest speaker at the 73rd annual Superior Chamber of Commerce banquet, at the Superior State University Student Center.

Dr. Liebenow Appointed Asst. Medical Director

Dr. Roland H. Liebenow, Lake Mills, recently was appointed an assistant medical director of Northwestern Mutual Life Insurance Co. Doctor Liebenow graduated in 1948 from the University of Wisconsin Medical School, is vice-chief of staff of Fort Atkinson Memorial Hospital and past chief of staff at St. Mary's Hospital in Watertown. He is a past president of the Jefferson County Medical Society and is currently serving as vice-president.

Winnebago State Hospital Adds to Staff

Drs. Gerald H. Gammell, Thomas J. Maleug, Quentin C. Case, recently were added to the staff of the Winnebago State Hospital. Doctors Gammell and Maleug graduated from the University of Minnesota and served their residencies at University Hospitals in Madison. Doctor Case graduated from St. Louis University, served his residency at St. Louis City Hospital and Milwaukee Children's Hospital, and practiced in Racine for four years.

Dr. Chapman Appointed to Staff

Dr. Marvin Chapman, Waupun, recently was appointed as chief of psychiatric service at Central State Hospital. Doctor Chapman graduated from the University of Wisconsin Medical School, received special training at the National Medical Center, Bethesda, Md., and served as base psychiatrist at Newport, R. I., and Chief of Psychiatrics in the Newport Naval Hospital.

Dr. Kasten Featured in Newspaper

Dr. Harry E. Kasten, Beloit, recently was featured in the BELOIT DAILY newspaper as an "Outstanding Beloiter." Doctor Kasten, a past president of the State Medical Society, is also a past president of the Beloit Rotary Club, the Beloit Physicians and Dentists, a member of the American Legion, the YMCA Board of Directors, the Beloit Softball League, a past county chief of the U. S. Citizens Defense Corps, and a Greater Beloit Association of Commerce board member. He was active on the City Council from 1934–41 and was its president in 1940. He was largely responsible for Beloit's million dollar Natatorium and for Turtle Creek Swimming Pool and the creation of the City Recreation Department. Another of Doctor Kasten's projects was organizing the Blue Cross–Blue Shield medical plan in Wisconsin and using Beloit as its testing ground as early as 1939.

Dr. Schroder Joins Medical Center

Dr. J. Richard Schroder, Janesville, engaged in practice for 20 years, has joined the Janesville Medical Center. He is certified by the American Board of Pediatrics and is a member of the American Academy of Pediatrics.

Dr. Bostian Joins Clinic

Dr. K. Eugene Bostian, Janesville, recently joined the staff of the Pember–Nuzum Clinic in Janesville. Doctor Bostian served his internship and residency in pediatrics at the University Hospitals, Madison.

Dr. Wrigley Joins Medical Clinic

Dr. John B. Wrigley, River Falls, recently joined the staff of the River Falls Medical Clinic. Doctor Wrigley graduated from Temple University Medical School and interned at Deaconess Hospital, Spokane, Wash. He served for two years with the United States Public Health Service in Alaska.

Dr. Ali Joins Clinic

Dr. Masroor Ali, Reedsburg, recently joined the Rouse Medical Clinic. Doctor Ali originally came from Pakistan. He served a year of internship at the Chicago American Hospital, a three-year resi-

Physicians whose names appear in italics are members of the State Medical Society.

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dency in surgery at Augustana Hospital, one and a half years of surgical residency at New York Memorial Hospital before he went back to Chicago for a final year of study and practice to qualify for the American Board of Surgeons. Doctor Ali also was an associate surgeon in a Seventh Day Adventist missionary hospital in Karachi, Pakistan.

Dr. Breister Opens Office

Dr. Karl A. Breister, Fond du Lac, recently opened his office in Fond du Lac. He graduated from Marquette University School of Medicine and served three and a half years on the staff at Mendota State Hospital, Madison. He completed his psychiatric residency at Traverse City State Hospital, Traverse City, Mich.

Dr. Schnicke New Medical Director

Dr. Elmer H. Schnicke, Madison, has been appointed the new medical director for the Jefferson County Home and Hospital. Doctor Schnicke is a native of Sheboygan, graduated from the Chicago Medical School, and practiced for 25 years at Wyanet, Ill., before coming to Madison.

Drs. Bernhard and Grace Guest Lecturers

Drs. Victor M. Bernhard, assistant professor of surgery at the Marquette University School of Medicine, and *Joseph B. Grace,* of the Green Bay Clinic, recently were the guest lecturers at the in-service program on the continuity of stroke and heart disease held in Two Rivers. The program was sponsored by the Two Rivers Municipal Hospital, and the guest lecturers were provided by the Wisconsin Heart Association.

Dr. Curreri Appointed to Advisory Board

Dr. A. R. Curreri, Madison, professor and chairman of the division of clinical oncology, has been appointed by the Secretary of Defense to the Armed Forces Institute of Pathology's Scientific Advisory Board of Consultants for a five-year term.

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increases and sustains peripheral blood flow

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for cold hands and feet and intermittent claudication

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Each teaspoonful (5 ml.) contains:

Nicotinic Acid . . . . . 75 mg.
Glycine . . . . . 750 mg.
in a palatable Sherry Wine Base
Alcohol 5%

Each lemon flavored chew-tab contains:

Nicotinic Acid . . . . . 75 mg.
Glycine . . . . . 750 mg.

INDICATIONS:

Poor circulation causing cold hands and feet or pain on walking. Mental symptoms of anoxia such as apathy, confusion, faintness, memory faults, and the "senile psychosis" often seen in older patients. For the more serious peripheral vascular disturbances such as . . . Raynaud's Disease, Meniere's Syndrome, intermittent claudication, diabetes, post-phlebitis syndrome, leg ulcers due to venostasis and chronic thrombophlebitis. Each 5 ml. elixir or Chew-tab contains 7 calories.

DOSAGE:

1 or 2 teaspoonfuls or 1 or 2 tablets 3 times a day before meals. The feeling of warmth and tingling of the skin is a desirable effect. If this reaction is too pronounced reduce dosage.

CONTRAINDICATIONS:

There are no known contraindications.

SUPPLIED:

8 oz. bottles and bottles of 100 chew-tabs.

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PHYSICIAN NEWS *continued*

Dr. Pandazi Opens Office

Dr. Andrew T. Pandazi recently opened offices in Menomonee Falls. He is on the staff of Community Memorial Hospital and also has been appointed to the provisional staff department of surgery, urology section, at St. Joseph's Hospital in Milwaukee. Doctor Pandazi graduated from the Marquette University School of Medicine and completed a combined Marquette University urology residency at Wood VA Center and Milwaukee County Hospital.

Dr. Himmelsbach Appointed Medical Director

Dr. William A. Himmelsbach, La Crosse, has accepted the position of corporate medical director at Dow Corning Corp. Midland, Mich., effective Oct. 1. He will organize and administer a corporate occupational medical program at Dow Corning which is jointly owned by Dow Chemical Co. and Corning Glass Work.

MEETINGS AND SPECIAL EVENTS HELD AT THE STATE MEDICAL SOCIETY "HOME" DURING THE MONTH OF SEPTEMBER 1967

5 Board of Trustees, Dane County Medical Society
5 Madison Anesthesiology Society
7 Division on School Health, SMS
12 Board of Directors, Wisconsin Association of Professions
12 Division on Ear, Nose, and Throat, SMS
13 Council on Health (formerly State Board of Health), Madison
14 Ninth Councilor District, Wisconsin State Dental Society
14 Ad Hoc Committee on the Medical Practice Act, SMS
15 Subcommittee, Maternal Mortality Study Committee, SMS
16 Leadership Training Seminar, Wisconsin State Medical Assistants Society
16 Executive Committee, SMS Council
17 Executive Board, Wisconsin State Medical Assistants Society
20 Trustees, SMS Realty Corp.
23 Cancer Study Committee, Wisconsin Regional Medical Program
23 State Universities Student Health Service Association
23 Maternal Mortality Study Committee and Division on Maternal and Child Welfare (Milwaukee)
28 Executive Committee, Commission on Medical Care Plans, SMS
28 Division on Vision, SMS
28 Cardiology Study Group, Wisconsin Regional Medical Program

Meetings not held in the Society "Home" but which have a direct relationship are printed in italics, with the location in parentheses.

Dr. Borge Joins Clinic

Dr. Alf F. Borge, Mauston, recently joined the Mauston Clinic and the staff of the Hess Memorial Hospital. Doctor Borge graduated from the University of Wisconsin Medical School and did residency work at Gorgas Hospital in the Canal Zone and Wood Veterans and Madison General hospitals. He served as a medical missionary in Madagascar for 10 years.

Dr. Hofmeister Named President-Elect

Dr. F. J. Hofmeister, Elm Grove, has been elected to the position of president-elect of the Central Association of Obstetricians and Gynecologists. The meeting was held in Detroit and Doctor Hofmeister presented a paper on "A Method of Suture Reinforcement of the Incompetent Cervix." From the Detroit meeting Doctor Hofmeister attended the meeting of the International Federation of Obstetricians and Gynecologists in Sydney, Australia. In Sydney, Doctor Hofmeister presented his experiences with a method of early detection of endometrial cancer—the endometrial biopsy—and also showed four of the movies produced by him.

Doctor Banyai Honored

Dr. Andrew L. Banyai, Chicago, Ill., clinical professor of medicine, emeritus, Marquette University School of Medicine, Milwaukee, was awarded honorary membership by the Medical Society of Vaparaiso, Chile, on Sept. 5. Also he received a plaque of honorary membership from the Confederacion "Cordic" of Argentina, in Buenos Aires, Sept. 7.

Dr. LaBissoniere Heads Medical Staff

Dr. Paul G. LaBissoniere, Milwaukee, has been appointed chief of the medical staff of St. Joseph's Hospital, succeeding the late Dr. George Kilkenny. Doctor LaBissoniere has been on the staff of St. Joseph's since 1950 and chairman of the Department of Internal Medicine since 1958.

Doctor Beckfield Chief Pathologist

Dr. William Beckfield, Eau Claire, has been named chief pathologist at Luther Hospital, Eau Claire. Doctor Beckfield, who has been on the pathology staff at Luther for several years, fills the vacancy left by *Dr. Willard Aronson* who has resigned to accept the position of director of laboratories at Mercy Hospital, Oklahoma City, Okla.

Dr. Goldstein Leaves Private Practice

Dr. D. N. Goldstein of Kenosha has discontinued his private practice in order to do specialized work. His practice is being taken over by *Dr. Nazario R. Cruz*. Doctor Goldstein is a member of the State Medical Society's Commission on Medical Care Plans which directs the operations of its insurance division, Wisconsin Physicians Service, and is editorial director of the WISCONSIN MEDICAL JOURNAL.

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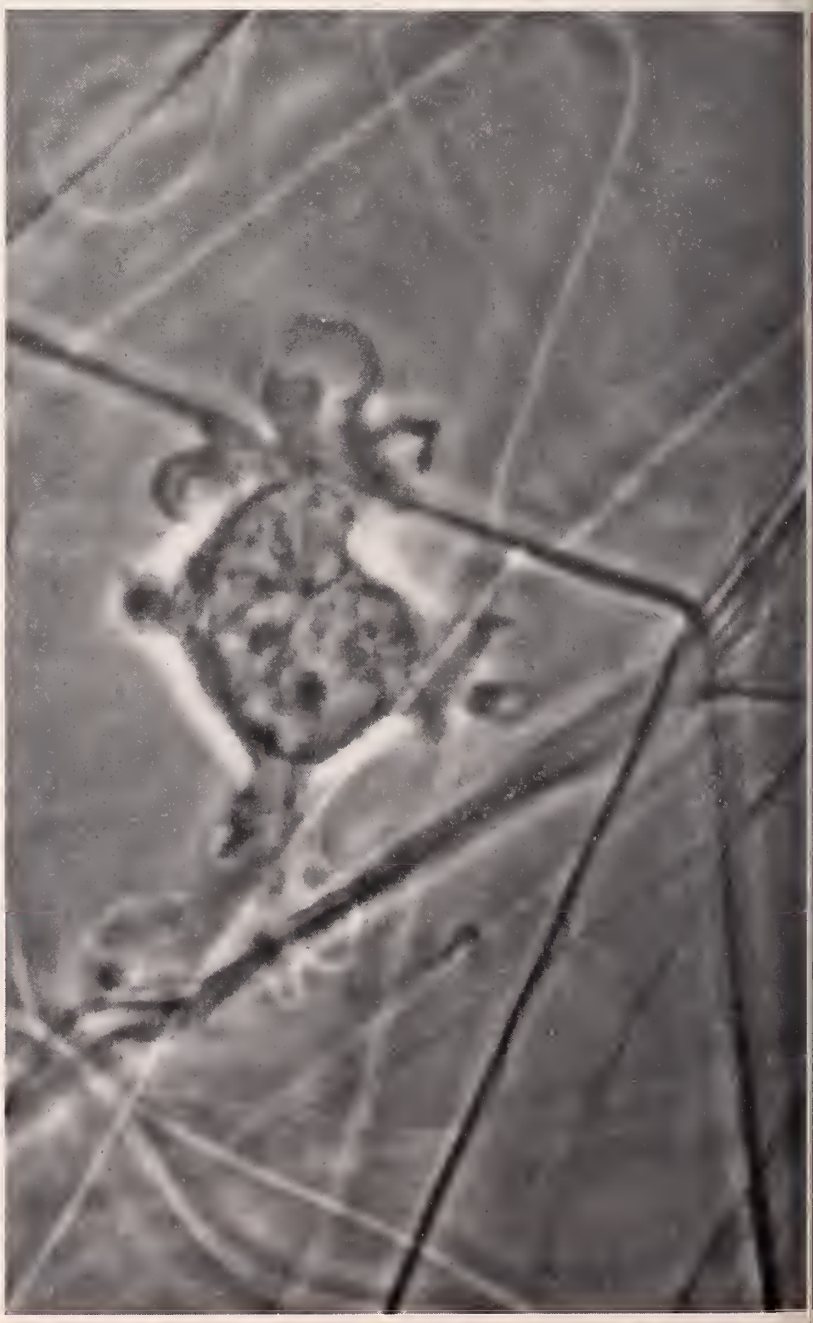
INFLAMMATION:
A cellular fight for life

A SYNTEX REPORT based on recently developed hypotheses about topical corticosteroids, including the cellular theories of inflammation by Thomas F. Dougherty, Ph.D., University of Utah.

You are looking at a fibroblast fighting for life. This cell—one of the most common found in connective tissue—has literally been poisoned by cytotoxins released from other cells that have ruptured. Soon, if the abnormal activity of this fibroblast does not cease, it, too, will rupture and die—one more casualty in the inflammatory wave of destruction precipitated by injury.

Until a short time ago no one had ever witnessed such a scene at the cellular level. Now, through advanced cinemicrographic techniques, it is possible to view and photograph the inflammatory process as produced experimentally in living animal tissue. This method permits new insight into the mechanism of inflammation and the role of corticosteroids in therapeutic management. Equally important, these techniques shed new light on factors that may make one corticosteroid more effective than another—factors that can be correlated with other chemical, biologic, and clinical parameters.



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Green Bay in the early 19th century

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COUNTY SOCIETY PROCEEDINGS

BROWN

The annual joint meeting of the Brown County Medical Society and the Brown County Bar Association recently met for a medical–legal dinner which was held at the Elks Club in Green Bay. *Dr. Leander Van Hecke,* former medical examiner for Milwaukee County, spoke on the role of the medical examiner's office in the community.

CHIPPEWA

The Chippewa County Medical Society met at the Hotel Northern in Chippewa Falls Sept. 5. Guest speaker was Dr. Al Hayles of the Mayo Clinic, Rochester, who spoke on "Practical Approach to Endocrine Diseases in Children."

DANE

New officers of the Dane County Medical Society were elected at the annual meeting Oct. 10 as follows:

Drs. Thomas V. Geppert, president-elect; *G. J. Derus,* vice-president; *E. L. Belknap, Jr.,* secretary–treasurer; *T. F. Heighway,* Middleton, and *F. N. Dukerschein,* Oregon, members-at-large of the Board of Trustees. *Dr. Gordon Davenport, Jr.,* Madison, is the new president.

Delegates elected for two-year terms are: *Drs. Laurence G. Crocker, G. E. Oosterhous, G. J. Derus,* and *Henry M. Suckle;* and alternates for two-year-terms are: *Drs. G. B. Tybring, John J. Mueller, Elmer E. Johnson,* and *James N. Moore. Drs. Phillip Schoenbeck* and *Arch E. Cowle* were elected as delegates for one-year terms.

OUTAGAMIE

The Outagamie County Medical Society is participating in sponsoring the visit of the Division of Health Mobile Survey unit throughout the county. The survey unit will conduct tests for diseases of the heart and lungs, high blood pressure, and diabetes. The unit will be in the area through Dec. 1, according to Society president, *Dr. James E. Gmeiner.*

* * *

THE AVERAGE AGE of the 5.8 million veterans of the Korean Conflict is 38, according to the Veterans Administration.

Physicians whose names appear in italics are members of the State Medical Society.

when bursitis hits a 280-lb. tackle, hit back with Butazolidin alka

Indications: Osteoarthritis, rheumatoid arthritis, rheumatoid spondylitis, psoriatic arthritis, acute gout, painful shoulder (peritendinitis, capsulitis, bursitis and acute arthritis of that joint), acute superficial thrombophlebitis.

Contraindications: Edema; danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia. The drug should not be given when the patient is senile or when other potent drugs are given concurrently. Large doses of Butazolidin alka are contraindicated in glaucoma.

Warning: If coumarin-type anticoagulants are given simultaneously, watch for excessive increase in prothrombin time. Instances of severe bleeding have occurred. Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea, sulfonamide-type agents and insulin. Carefully observe patients receiving such therapy. Use with great caution in the first trimester of pregnancy.

Precautions: Before prescribing, carefully select patients, avoiding those responsive to routine measures as well as contraindicated patients. Obtain a detailed history and a complete physical and laboratory examination, including a blood count. The patient should not exceed recommended dosage, should be closely supervised and should be warned to discontinue the drug and report immediately if fever, sore throat, or mouth lesions (symptoms of blood dyscrasia); sudden weight gain (water retention); skin reactions; black or tarry stools or other evidence of intestinal hemorrhage occur. Make regular blood counts. Discontinue the drug immediately and institute countermeasures if the white count changes significantly, granulocytes decrease, or immature forms appear. Use greater care in the elderly and in hypertensives.

Adverse Reactions: The most common are nausea, edema and drug rash. Swelling of the ankles or face may be minimized by withholding dietary salt, reduction in dosage or use of diuretics. In elderly patients and in those with hypertension the drug should be discontinued with the appearance of edema. The drug has been associated with peptic ul-

For 280-lb. tackles—or 108-lb. housewives—Butazolidin alka can hasten recovery from the agonizing pain of shoulder bursitis.

It's not for every patient. Check carefully the Contraindications, Warning and Precautions shown below.

And adverse reactions may occur. The most common are nausea, edema and rash. Rarely, agranulocytosis has been reported. All adverse reactions are listed below, too.

Play-for-pay or workaday patients—when they come up with shoulder bursitis and your clinical judgment indicates Butazolidin alka—go with it.

And watch the comeback.

cer and may reactivate a latent peptic ulcer. The patient should be instructed to take doses immediately before or after meals or with milk to minimize gastric upset. Mild drug rashes frequently subside with reduction of dosage. However, rash accompanied by fever or other systemic reactions usually requires withholding medication. Purpuric rash has also been reported. Agranulocytosis, exfoliative dermatitis, Stevens-Johnson syndrome, or a generalized allergic reaction similar to serum sickness may occur and require permanent withdrawal of medication. Stomatitis, salivary gland enlargement, vomiting, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported. While not definitely attributable to the drug, a causal relationship cannot be excluded. Thrombocytopenic purpura and aplastic anemia may occur. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hyperglycemia, hepatitis, jaundice, and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently. Moderate lowering of the red cell count due to hemodilution may occur. 6509-V(B)R2

Butazolidin® alka

Capsules

100 mg. phenylbutazone
100 mg. dried aluminum hydroxide gel
150 mg. magnesium trisilicate
1.25 mg. homatropine methylbromide

Dosage in painful shoulder: Initial: 3 to 6 capsules daily in 3 or 4 equal doses. Trial period: 1 week. Maintenance dosage should not exceed 4 capsules daily; response is often achieved with 1 or 2 capsules daily.

For complete details, please see full prescribing information.

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SPECIALTY SOCIETY PROCEEDINGS

Wisconsin–Upper Michigan Society of O–O

The Wisconsin–Upper Michigan Society of Ophthalmology and Otolaryngology met Sept. 16–17 at Bailey's Harbor for a combined business and scientific session.

Two physicians from the Mayo Clinic, Rochester, Minn., presented the scientific lectures: Dr. Kenneth Devine on "Carcinoma of the Larynx" and "Lesions of the Oropharynx" and Dr. John W. Henderson on "Proptosis Patterns" and "Ophthalmic Topics of General Interest."

Dr. Ryder President WSIM

DR. EDWARD K. RYDER, JR., Madison (left), was installed as president of the Wisconsin Society of Internal Medicine during the organization's annual meeting and scientific program, Sept. 15–16, at Land O'Lakes. Doctor Ryder's first official act was to present a distinguished service award to outgoing president Dr. John H. Wishart, Eau Claire (right). Doctor Wishart received the award in recognition of his service to the Society during the past 10 years and which culminated in his term as president during 1966–67.

The Wisconsin Society of Internal Medicine is a medical specialty organization with 200 internist members from throughout Wisconsin. The scientific program for this meeting appeared in the August issue at page 7.

Physicians whose names appear in italics are members of the State Medical Society.

Wisconsin Surgical Society

The fall meeting of the Wisconsin Surgical Society was held Sept. 14–16 at the Gateway Inn, Land O' Lakes.

The scientific program on Sept. 15 included the following speakers and topics: *Dr. James R. Hoon*, Sheboygan, The Earlier Diagnosis of Stomach Cancer; *Dr. William H. Frackelton*, Milwaukee, The Prevention of Ring Avulsion Injuries; *Dr. William Wolberg*, Madison, The Relation of DNA Thymine Synthesis to Human Tumors to Fluorinated Pyrimidine Sensitivity; Drs. *George J. Korkos* and George Cochran, Jr., Milwaukee, Reconstruction of Oral Cutaneous Fistula in Irradiated Areas; *Dr. William A. Kisken*, Madison, The Function of the Thymus in the Immune Response; Drs. *Marvin Wagner* and George J. Reul, Jr., Milwaukee, The Use of Spandex as a Vascular Patch Graft Material; Drs. *Michael A. Polacek* and Peter M. Sanfelippo, Milwaukee, Antibiotic Bowel Preparation and Complications in Colon Resection; and Dr. David P. Boyd, Lahey Clinic, Boston, Mass., who presented the guest lecture.

The Sept. 16 program consisted of presentations by Marquette residents as follows: Dr. Kenneth R. Tucker, Division of Surgery, Surgical Implications of Salmonellosis; Dr. James F. Romer, Division of Surgery, Subclavian Catheterization, Technique and Pitfalls; Dr. Jafar Shah–Mirany, Department of Thoracic–Cardiovascular Surgery, Division of Surgery, Physiologic Significance of Diaphragmatic Eventration; Dr. Ivan Shapiro, Division of Surgery, Management of Subclavian Steal Syndrome; Dr. Robert W. Crow, Division of Surgery, Ruptured Abdominal Aortic Aneurysm; and Dr. George A. Cochran, Jr., Division of Surgery, Experimental Venous Thrombosis and Thrombectomy.

A panel discussion on The Iron Curtain of Surgery was moderated by *Dr. Ben R. Lawton*, Marshfield. Panel members were Drs. David P. Boyd, *Anthony R. Curreri*, *Donald E. Koepke*, and *Wilson Weisel*.

The best resident paper award was presented to Doctor Cochran at the evening dinner. Doctor Boyd also addressed the members that evening.

Wisconsin Radiological Society

The eighteenth annual meeting of the Wisconsin Radiological Society was held at the Pioneer Motel and Marina, Oshkosh, Sept. 15–17. Guest speakers were Dr. John Fennessy, from the University of Chicago Hospitals and Dr. William Martel, University of Michigan Hospitals, Ann Arbor, Mich. Doctor Fennessy spoke on "Bronchial Brushing and Transbronchial Biopsy of Peripheral Lung Lesions." Doctor Martel lectured on "Lung Findings in Rheumatoid Disease."

Dr. Charles Benkendorf, Green Bay, was elected president to succeed *Dr. Howard Mauthe* of Fond du Lac. *Dr. Robert Feulner*, Waukesha, is president-elect and *Dr. Wayne Rounds*, Madison, was named

vice-president. *Dr. Harold F. Ibach*, Milwaukee, will continue as secretary and treasurer. *Dr. Gene Sengpiel*, Milwaukee, and *Dr. Gene Armstrong*, Kenosha, were elected to the board of directors. *Dr. Eugene Betlach*, Janesville, was elected to the board of censors. *Dr. Leslie E. Jones*, Fond du Lac, and *Dr. Lawrence L. Larsen*, Milwaukee, will continue as councilors to the American College of Radiology. *Dr. Howard Bayley*, Beaver Dam, and *Dr. Loren Hart*, Green Bay, were reelected alternate councilors.

New members accepted into the society were *Drs. Ronald Grossman* and *Alvin Zautcke* of Milwaukee, *Dr. John Swingle* of Madison, *Drs. Dayton Hinke* and *Marvin Hinke* of Marshfield, *Dr. James Brown* of Eau Claire, Dr. Robert Kinde of Appleton, and Dr. Thomas Vechinski of Wausau.

The program chairman was Doctor Feulner.

Wisconsin Psychiatric Association

Dr. Harold Rosen, Baltimore, Md., spoke at the Oct. 14 meeting of the Wisconsin Psychiatric Association (WPA). Doctor Rosen discussed "Abortion, The Psychiatrist and The Law." He is the author of the forthcoming book "Abortion in America" to be published by Beacon House.

The dinner meeting was held at the Holiday Inn–Central in Milwaukee. The WPA Council met in the afternoon, followed by a business meeting of the Milwaukee Chapter of the WPA. The Milwaukee Chapter was host for the meeting.

PARAMEDICAL ANCILLARY GROUPS

Wisconsin Medical Technologists

The Wisconsin Association of Medical Technologists, Racine–Kenosha district, held its first 1967–1968 season meeting at St. Mary's Hospital in Racine Sept. 12. Guest speaker was *Dr. Victor A. Baylon*, pathologist at St. Mary's, who spoke on "The Uses of Radioactive Isotopes in Clinical Medicine."

Wisconsin Medical Alumni Association

An annual dinner–reception of the Wisconsin Surgical Alumni, in conjunction with the American College of Surgeons meeting, was held Oct. 3 at the Pick Congress Hotel in Chicago. A series of slides on campus scenes and activities was shown during the informal program. *Dr. Robert C. Hickey*, professor and chairman of surgery, and the Surgical Staff at Wisconsin, invited everyone who had been connected with the Medical School Surgery Department, including former interns, residents, and students.

An informal program, featuring Medical School Dean, *Dr. Peter L. Eichman*, and other faculty members, will follow a buffet dinner at the annual upstate meeting of the Wisconsin Medical Alumni Association on Dec. 7 at Hotel Charles, Marshfield. *Dr. George E. Magnin* of Marshfield has made arrangements for the dinner. Reservations may be made with the Association, 333 N. Randall Ave., Madison, Wis. 53706.

A fall homecoming meeting, scheduled for Oct. 28, has been planned when Wisconsin meets Northwestern on the football field. A scientific program in the morning will precede the afternoon game.

Cobalt Unit, Stevens Point Hospital

A $7,941 donation has assured the installation of a Cobalt 60 radiation therapy unit at St. Michael's Hospital, Stevens Point. The Stevens Point area health foundation made the donation as a down payment for the $40,000 machine. The foundation was begun a year ago to improve medical facilities in Portage county and is supported by the United Fund, and donations from wills and memorials.

Coronary Care Unit, Cudahy Hospital

A coronary care unit opened in July at Trinity Memorial Hospital in Cudahy, according to an announcement by *Dr. Rocco Latorraca*, chief of the medical staff. *Dr. Carl Chelius* is chairman of the hospital's coronary care committee which directed the preparation and planning of the unit. Other committee members include: *Dr. Robert C. Tabet*, *Dr. George Spencer*, *Dr. D. Nuyda*, and *Dr. Valerio Turgai*.

Visiting Professor of Neurological Surgery

Dr. Oscar Sugar, Professor of Neurological Surgery, University of Illinois College of Medicine, was Helen Halverson Visiting Professor of Neurological Surgery at The University of Wisconsin Medical Center from Sept. 25 to Sept. 28. The Visiting Professorship is provided by Mr. Harold F. Halverson and family of Beloit.

Madison Medical Technology Society Formed

The newly organized Madison Area Society of Medical Technologists held its first meeting Sept. 12 at the Wisconsin Center. A guest panel discussed "Functions and Nation-State-Local Societies: 'Why You Should Belong to Them'."

The new society is an affiliate and branch organization of the American Society of Medical Technologists and the Wisconsin Association of Medical Technologists.

Physicians whose names appear in italics are members of the State Medical Society.

Milwaukee County Medical Assistants

Dr. Walter J. Woloschek spoke at the first meeting of the 1967–1968 season of the Milwaukee County Medical Assistants Society Sept. 20. The meeting, open to all medical personnel in Milwaukee County, was held at St. Mary's Hospital.

Helen Crahen Honored at UW

Miss Helen Crahen, emeritus secretary of surgery at the University of Wisconsin Medical School, was honored at a recognition ceremony Aug. 21 by members of the UW surgery faculty.

Dr. Robert C. Hickey, professor and chairman of surgery, presented Miss Crahen, who worked in the department for 42 years, with a framed sheepskin scroll, signed by about 75 faculty members and residents, and a check, both given in appreciation for her dedicated service.

MISS HELEN CRAHEN, former secretary for the department of surgery, UW Medical School, receives a scroll from Dr. Robert C. Hickey, chairman of the department.

Contributions for Miss Crahen came not only from present faculty members but also from former faculty and residents now living as far away as San Francisco and Phoenix. Along with the check came some travel folders. The department is hopeful that Miss Crahen might take a well deserved vacation.

Nursing Education Project Grants

A program of nursing education specially designed to recruit men and women of mature age, rather than recent high school graduates, and a course in the post-surgical care of patients who must adapt to radical changes in personal hygiene are among the new learning opportunities nursing schools are offering with grants from the Division of Nursing, U. S. Public Health Service.

In the second quarter of 1967, 26 nursing schools received $1,323,721 in Project Grants for Improvement in Nurse Training, as authorized by the Nurse Training Act of 1964. Sharing in these awards, which are now being announced for the first time, are all three types of nursing education programs—hospital schools, two-year associate degree programs, and nursing programs leading to a baccalaureate degree.

The University of Wisconsin, Madison, has been included in the new Project Grants and has been designated to receive $109,507, the third highest amount granted to the 26 schools. The grant will encompass a design for a model baccalaureate program, both as to content and most applicable teaching methodologies, and will cover a two-year period.

The first Project Grants for Improvement in Nurse Training were awarded in 1965. To date, 95 nursing education programs in 35 States, the District of Columbia, and Puerto Rico have designed and undertaken one or more projects to correct their shortcomings, provide a higher level of training, and augment both local and regional resources for the education of professional nurses.

The amount expended in Project Grants to help schools of nursing set new sights, create and apply new teaching tools, and broaden their curriculums and clinical resources now stands at nearly $7½ million. When completed, the 116 projects undertaken to date will represent a $12 million federal investment to expand the scope and raise the quality of nursing education.

Heart Group Supports SMS Speakers

The Physician Education Committee of the Wisconsin Heart Association has voted to give financial support to the speaker's bureau of the State Medical Society.

The announcement was made by Dr. Richard H. Wasserburger, chief of cardiology, VA Hospital, Madison, and chairman of the WHA Physician Education Committee, following the group's August 23rd meeting.

The financial aid will be used to meet the expenses of the circuit speakers and county speakers divisions of the State Medical Society's Speaker's Bureau.

Technology Students Complete Course

Four medical technology students received pins and certificates in a ceremony at the clinical laboratory of St. Agnes Hospital, Fond du Lac, Aug. 30. Sister M. Joan, C.S.A., administrator of the hospital, distributed the certificates and *Dr. R. E. Carlovsky*, associate pathologist, presented the pins to Mrs. Patricia Casetta, Fond du Lac; Miss Patricia Maresch, Mauston; Miss Nola Keller, Forest Junction; and Miss Elaine DeDryver, Green Bay.

The students spent 12 months learning theory and practical technique under the direction of *Dr. R. W. Steube*, director of the school.

OBITUARIES

Dr. Louis Schmit, 98, Wauwatosa, died July 30, 1967, in Milwaukee.

Doctor Schmit graduated from the Wisconsin College of Physicians and Surgeons in 1902, forerunner of the Marquette University School of Medicine. He took postgraduate training at the Chicago EENT College, the Illinois Charitable Eye and Ear Infirmary, and at the universities of Wuerzburg, Germany, and Vienna, Austria. Doctor Schmit had practiced in the Milwaukee area for 52 years and retired at the age of 85 years.

He was a life member of the State Medical Society of Wisconsin, the Marquette University Alumni Association, and the Milwaukee Academy of Medicine. Doctor Schmit was a member of The Medical Society of Milwaukee County, member of the 50-year club of the State Medical Society of Wisconsin, and American Medical Association.

Surviving are a son, Otto A., Whitefish Bay, and a daughter, Emily, Wauwatosa.

Dr. Theodore W. Dasler, 54, Marshfield, died Aug. 17, 1967, in Rochester, Minn.

Born in Scranton, Pa., he graduated from the University of Wisconsin Medical School in 1937 and interned at St. Luke's Hospital in Duluth, Minn. During World War II, he saw active duty on a destroyer in the battle of the Coral Sea and the battle of Midway. He also took part in the Aleutian campaign. Before entering the Navy in 1941, Doctor Dasler practiced medicine in Amery and Deer Park. After discharge from the Navy in 1947, he took a basic course in ophthalmology at Northwestern University and spent two years in ophthalmology residency at the Veterans Hospital in Hines, Ill. He had practiced in Eau Claire and Milwaukee before joining the Marshfield Clinic in 1961.

Doctor Dasler was a member of the Wood County Medical Society, the State Medical Society of Wisconsin, and American Medical Association. He also was a member of the American Academy of Ophthalmology and Otolaryngology and the Upper Midwest Society of Ophthalmologists and Otolaryngologists.

Surviving are his widow, Helen; and five children, Theodore Jr., Martin, David, Patricia, and Jonathan.

Dr. Hugh P. Conway, 90, Spring Valley, died Sept. 22, 1967, in Eau Claire. Doctor Conway graduated in 1901 from the University of Illinois College of Medicine and has practiced medicine in the Spring Valley area since 1902. In 1952, he was honored at a testimonial dinner for his over 55 years of service to the community. He is survived by one daughter, Mrs. Elmer Kuehl, Spring Valley.

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SOCIETY RECORDS

MEMBERSHIP REPORT AS OF AUGUST 31, 1967

NEW MEMBERS

Camacho, Ernesto M., 345 North Madison St., Waupun 53963

Kochell, Richard L., 1344 Creston Park Dr., Janesville 53545

REINSTATED

Luck, Allen, 4139 North Bartlett Ave., Milwaukee 53211

CHANGES OF ADDRESS

Aronow, Cedor, Fort Bragg, North Carolina, to 3003 West Good Hope Rd., Milwaukee 53209

Babbitt, Donald, 3003 West Good Hope Rd., Milwaukee 53209

Bessiere, Milton C., Madison, to Box 106, Alexander, Ark., 72002

Bogle, Warren C., 3696 Lake Mendota Dr., Madison 53705

Borge, Alf F., West Salem, to Mauston Clinic, Mauston

Boyd, Andrew, 3003 West Good Hope Rd., Milwaukee 53209

Bremer, Elvin M., 8860 Shoshore, Northridge, Calif., 91324

Bryan, Albert R., Madison, to 1010 S. Edgewood, La Grange, Ill., 60525

Bugarin, N. L., 221 E. Washington Ave., Tomahawk 54487

Bukosky, Richard J., Wauwatosa, to 16085 Heritage Lane, New Berlin 53151

Creasy, L. E., South Wayne, to 3901 Bahia Vista St., Lot 101, Sarasota, Fla., 33580

Curet, Luis B., New Haven, Conn., to Dept. of Gyn–OB, Univ. of Wisconsin School of Medicine, Madison 53705

Davis, Jean, 3003 West Good Hope Rd., Milwaukee 53209

Edwards, Albert C., 2500 Raylor Ave., Racine 53403

Enders, Lawrence J., San Francisco, Calif., to Sam Box 4115, Brooks AFB, Texas 78235

Felton, Arvin L., Madison, to USAFH Wiesbaden, USAFE Box 577, APO New York 09220

Flint, Charles H., Wauwatosa, to 8700 West Wisconsin Ave., Milwaukee 53226

Francisco, O. M., 221 East Washington Ave., Tomahawk 54487

Geldner, Barbara, 207 East Wisconsin Ave., Neenah 54956

Gladstone, Herman P., 2700 Marshall Court, Madison 53705

Graham, Albert P., 1779 South Commercial, Neenah 54956

Haines, M. C., 628 West Irving Ave., Oshkosh 54901

Haukohl, Robert S., Milwaukee, to 7695 Almansa St., Coral Gables, Fla., 33143

Horwitz, S. F., 8988 North Silver Brook Lane, Milwaukee 53223

Inda, Gregory, 5757 West Oklahoma Ave., Milwaukee 53219

Johnson, Frank K., Beloit, to 210 S. Kenosha Dr., Madison 53705

Kelley, Walter M., 351 West Heather Court, Eau Claire 54701

Kobelt, Carl C., 1017 Lincoln Blvd., Manitowoc 54220

Lakritz, Amrum, 408 S. River St., Janesville 53545

Lameka, Peter, 35312 Genesee Lake Rd., Oconomowoc 53066

May, James E., Milwaukee, to Armed Forces Institute of Pathology, Washington, D. C., 20305

McCreadie, Samuel, 3003 West Good Hope Rd., Milwaukee 53209

Mellencamp, Frank, 3003 West Good Hope Rd., Milwaukee 53209

Montgomery, Edwin Jr., Thiensville, to 3003 West Good Hope Rd., Milwaukee 53209

Nepomuceno, Ruben A., Black Creek, to 5530 South Illinois Ave., Cudahy 53110

Olson, Neiland R., Milwaukee, to 2634 Mead Circle, Colorado Springs, Colo., 80907

Pinell, Octavio C., Milwaukee, to 11324 Haven Hurst, Granada Hill, Calif., 91344

Richany, S. F., Washington, D. C., to Mid-Missouri Mental Health Center, Univ. of Missouri Medical Center, Columbia, Mo., 65201

Schwartz, A. B., 3003 West Good Hope Rd., Milwaukee 53209

Southcott, Walter, 3003 West Good Hope Rd., Milwaukee 53209

Spicuzza, Salvatore A., 625 Apple Valley, San Antonio, Tex., 78242

Stein, Ronald W., Delafield, to 4060 North 163, Brookfield 53005

Tang, Tom, 3003 West Good Hope Rd., Milwaukee 53209

Taylor, Claude A., Atlanta, Georgia, to 6341 Landfall Dr., Madison

Thomas, Walton, 3003 West Good Hope Rd., Milwaukee 53209

Ware, Robert J., Hazel Green, to Kampine Clinic, Marathon 54448

Wiley, Darrell B., Los Angeles, Calif., to 1419 Campbell St., Glendale, Calif., 91207

Willson, Donald, 3003 West Good Hope Rd., Milwaukee 53209

Yutuc, Wilfrido R., Seattle, Wash., 2116 Park Ave., La Crosse 54601

Zimmerman, Lois, Arcadia, to 46 Hall St., Tiffin, Ohio 44883

Zubatsky, David J., Milwaukee, to 615 Chipwood, Orange, Calif., 92667

REMOVED FROM MEMBERSHIP

Anderson, Jon A., Milwaukee County, transferred to Montana

Fricano, Salvatore, Milwaukee County, removed per County Secretary

Meloy, Gissla M., Milwaukee County, resigned

Phillips, Richard L., Milwaukee County, transferred to Illinois

Stolp, Sherwood B., Milwaukee County, removed per County Secretary

Trump, David S., Milwaukee County, resigned

Warpinski, Marion A., Brown County, transferred to Nevada

DEATHS

Dasler, Theodore W., Wood County, Aug. 17, 1967

Recent Wisconsin Licentiates

The following physicians were granted licenses by oral and written examination by the State Board of Medical Examiners at a meeting in Madison, January 12, 13, 14, 1966.

Name	*School of Graduation*	*Year*	*City*
Ali, Syed M.	University of Panjab, Pakistan	1958	Baltimore, Md.
Gabriel, Reynaldo P.	University of Santo Tomas	1954	Wausaukee
Werner, Mario G.	University of Buenos Aires	1957	Milwaukee

The following physician was granted a license by oral examination by the State Board of Medical Examiners at a meeting in Madison, April 22, 1966.

Kuperman, Solomon	University of Illinois	1961	Madison

The following physicians were granted licenses by oral and written examination by the State Board of Medical Examiners at a meeting in Milwaukee, July 12, 13, 14, 1966.

Altenberg, Barry M.	University of Bologna, Italy	1963	Skokie, Ill.
Dressler, Joachim A. W.	University of Frankfurt	1947	Penfield, N. Y.
Esener, Ismail	University of Istanbul	1952	Union Grove
Greblo, Zorislav	University of Zagreb	1953	Madison
Hapke, Edith J.	Free University of Berlin	1956	Wood
Oxman, Herbert A.	University of Wisconsin	1966	Rochester, Minn.
Pintar, Karl	University of Vienna	1954	Waukesha
Reyes, Cesar N., Jr.	University of Santo Tomas	1955	Marshfield
Vogt, Philip J.	University of Wisconsin	1965	Oakland, Calif.
Yao, Filemon C.	University of Santo Tomas	1958	Lyons, Ill.
Zurek, Wladyslaw Z.	University of Zurich	1958	Marshfield

The following physicians were granted licenses by oral examination by the State Board of Medical Examiners at a meeting in Milwaukee, July 13, 1966.

Carter, Loren J., Jr.	Howard University	1965	Madison
Hanson, James C.	University of Wisconsin	1965	Madison
Kief, John J.	Marquette University	1965	Fond du Lac

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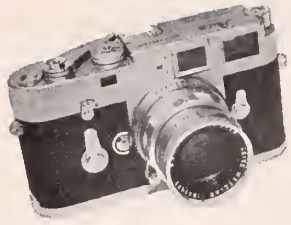


ANNUAL PHOTOGRAPHY CONTEST

OPEN TO MEMBERS OF THE STATE MEDICAL SOCIETY

EASY TO ENTER

Contest rules have been simplified to make it easier to enter your photographs.

Any black and white or color photo may be entered, either mounted, framed or unmounted. Photos may be enlarged to any size up to 16 x 20 inches, with a minimum recommended size of 5 x 7 inches.

Prizewinning photographs, if received unmounted, will be mounted on 16 x 20 boards for display at the State Medical Society Annual Meeting.

CLASSIFICATIONS

Medicine, Travel, People (at play and at work), Animals, Pictorial (landscape, objects, still life, etc.).

ENTRIES

There is no limit to the number of entries allowed to any exhibitor. All entries must be at the State Medical Society headquarters in Madison by April 1, 1968.

Entries must carry the following information on the back of the photo or mounting board: Title, class entered, name and address of exhibitor. There shall be no writing or printing on the front of the mounting board or any photo. All photos entered must be taken by the entrant but developing, enlarging and mounting need not be done by him.

AWARDS

Each division, black and white or color, will be judged separately and the following awards given to each classification: First place, second place and third place. In addition, three honorable mention awards will be given to each classification. There will be an award of "Best In Show" given to the best entry, either black and white or color. Trophies will be given to all first place winners and to the "Best In Show" and ribbons for all other awards.

JUDGING

Judging will take place prior to the showing of entries at the Annual Meeting. Winners will be notified of their awards as soon after judging as possible.

MAIL THIS ENTRY AND ALL PHOTOS TO:

PHOTO CONTEST, State Medical Society of Wisconsin,
Box 1109, Madison, Wis. 53701

Name _____

Address _____

CLASS	NUMBER ENTERED (Black & White)	(Color)	TOTAL
Medicine	_____	_____	_____
Travel	_____	_____	_____
People	_____	_____	_____
Animals	_____	_____	_____
Pictorial	_____	_____	_____

OFFICIAL CALL
for Scientific Exhibits

1968 ANNUAL MEETING, MILWAUKEE, MAY 14–15–16

★

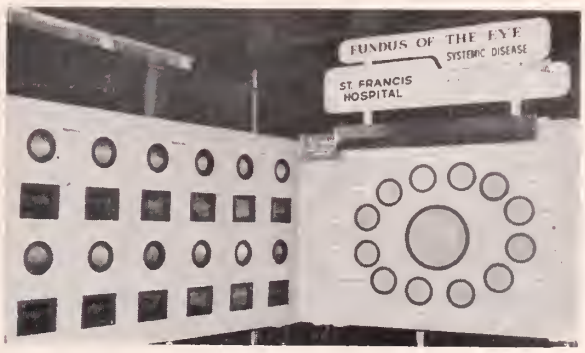
The Commission on Scientific Medicine is desirous of knowing which members of the State Medical Society are interested in presenting scientific exhibits in connection with the 1968 Annual Meeting. The exhibits will be located in **Milwaukee.**

To facilitate arrangements for the proper location of the scientific exhibits, individuals and organizations desiring space in the 1968 meeting are requested to file an application before Feb. 1, 1968, giving a full description of the exhibit, the amount of space required, and the basic equipment which will be needed. *Assignments made as exhibits approved by Commission on Scientific Medicine.*

In-state exhibitors will have the following facilities provided by the State Medical Society: Velour booth, electrical connection, shelving or tables, and identifying sign.

The exhibitor must furnish: Transportation costs of exhibit, special radiologic viewing boxes, special chrome furniture or rugs, special lighting equipment, and half the cost of any drapes rented (rented through Badger Exposition Service, Inc., Milwaukee, on form to be furnished all exhibits scheduled).

Booths for scientific exhibits will have dark maroon velour background, 8′ in height, and 8′ velour side dividers (such as is shown in illustration at right).



No exhibit may exceed a height of 7′ from the floor.

Counters (3′ high and 20″ wide) or tables (30″ high and 3′ wide) are available for viewboxes or displays to be raised above floor level.

Those interested in providing an exhibit are required to file an application and a full description of the exhibit. **DEADLINE FOR APPLICATIONS: FEB. 1, 1968.**
Address your communications to:

BEN R. LAWTON, M.D.
Director of Scientific Exhibits
% State Medical Society of Wisconsin
Box 1109
Madison Wis. 53701

USE FORM ON OPPOSITE PAGE →

APPLICATION

FOR PARTICIPATION IN THE SCIENTIFIC EXHIBIT

1968 Annual Meeting Milwaukee May 14–15–16

★

Fill out the following information and mail to:

BEN R. LAWTON, M.D., *Director of Scientific Exhibits*
State Medical Society of Wisconsin
Box 1109, Madison, Wisconsin 53701

1. Title of exhibit: _____

2. Description of exhibit (space allowed below for 200-word description): _____

3. **Feet Required:** _____ **(In figuring feet required, remember the space is 8′ deep, and your exhibit can use sides as well as back.)**
   (Space is scarce so ***do not request more than is necessary****)*

4. Will radiologic viewing boxes be used? If so, will you furnish them? _____
   (The State Medical Society does not have equipment of this character available).

5. Name of exhibitor: _____

6. Name of institution cooperating in exhibit: _____

DEADLINE: All applications must be filed by Feb. 1, 1968. Assignments made on Feb. 1.

BOOK REVIEWS

HANDBOOK OF OBSTETRICS AND GYNECOLOGY

By Ralph C. Benson, M.D., Professor of Obstetrics and Gynecology and Chairman, Department of Obstetrics and Gynecology, University of Oregon Medical School, Hospitals, and Clinic, Portland, Ore. Lange Medical Publications, Los Altos, Calif. 1964. 659 pages. Price: $5.00.

"Designed as a ready reference for the student, house officer, and practitioner, and as an abbreviated, but reasonably comprehensive companion to the large standard textbooks, this compact volume."

Most books of this type are introduced to medical readers with the above quote, time worn, occasionally appropriate, but certainly over-used. This volume clearly fits this quoted description. It consists, in the main, of simple declarative statements presented in telegraphic style. The unadorned syntax is a forceful feature, but does not lend itself to easy reading or retention of the material presented. The volume, then, is useful as a quick reference for most obstetric and gynecologic problems, and carried in the coat pocket of the house officer, will prove its value as he is faced with the many clinical problems of a busy service.—A. L. KENNAN, M.D.

OZAENA, A MANIFESTATION OF IRON DEFICIENCY

By Ivan Bernat, Director, Second Department of Internal Medicine, Consulting Haematologist, Robert Karoly Central Hospital, Budapest. Translation edited by Miss Esme Hadfield, Consulting Otolaryngologist, High Wycombe and Amersham Hospitals, Buckinghamshire. With a foreword by Ronald MacBeth, Director, Department of Otolaryngology. Radcliffe Infirmary, Oxford. Pergamon Press Inc., New York. 1965. 116 pages. Price: $8.50.

The author has presented an interesting and reasonable hypothesis regarding the pathogenesis of chronic atrophic rhinitis. Other theories of pathogenesis are discussed and critical analyses of these are included.

Personal investigation includes clinical, hematological, and biochemical data in 65 cases of ozaena. Hyposiderosis was demonstrated in all of these. The clinical response to iron therapy in 53 cases is reviewed. Iron was administered parenterally to adults and orally to children. Results were as follows:

1. Free of symptoms _____ 52.8%
2. Considerable improvement _____ 30.2%
3. Moderate improvement _____ 9.4%
4. Unchanged _____ 7.5%

The author concludes: "These results prove beyond any doubt that ozaena is an iron-deficiency disease. Iron and iron alone is the essential therapeutic agent."

This monograph should be of particular interest to otolaryngologists and other physicians who have dealt with this disease. Evaluation of iron deficiency anemia and iron therapy in these patients seems warranted.—RICHARD H. WARD, M.D.

BOOKSHELF

New books received are acknowledged in this section. From these books, selections will be made for reviews in the interest of the readers and as space permits, Reviews are written by members of the faculty of the University of Wisconsin Medical School. Books here listed will be available on loan from the Medical Library Service, S.M.I. Building, North Charter Street, Madison, Wisconsin 53706

HANDBOOK OF CLINICAL LABORATORY DATA

Editor, Henry C. Damm, Ph.D., Western Reserve University; Chairman, Advisory Board and Associate Editor, John W. King, M.D., Ph.D., The Cleveland Clinic Foundation (Ohio). The Chemical Rubber Co., Cleveland, Ohio 44114. 1965. 469 pages. Price: $12.50.

The *Handbook of Clinical Laboratory Data* represents a comprehensive compilation of the type of data commonly encountered as a result of clinical chemistry tests. It also discusses briefly the relationships of some of the tests to physiologic disorders. This book is a valuable desk reference to the practicing clinical chemist and possibly to the practicing physician. I would recommend this as a desk reference for anyone who is faced with the problem of interpreting clinical chemistry results. The descriptions of the various clinical tests, their interpretations as related to body functions, etc., are useful also in the interpretation of the laboratory results. As a clinical chemist, I find this book to be a valuable desk reference. It is also a book I would recommend for shelving in the library.—R. H. LAESSIG, M.D.

APPLIED HYPNOSIS AND POSITIVE SUGGESTION

In Medicine, Dentistry, and Patient Care. By George A. Ulett, M.D., Ph.D., Professor and Chairman, Department of Psychiatry at the Missouri Institute of Psychiatry (St. Louis), University of Missouri School of Medicine; Director, Division of Mental Diseases for the State of Missouri, and Donald B. Peterson, M.D., Superintendent, Fulton State Hospital, Fulton, Mo. C. V. Mosby Co., St. Louis, Mo. 1965. 134 pages. Price: $8.50.

This book appears to be written for physicians of various disciplines ranging from surgery to dentistry. In fact, the authors state in their conclusion to this volume, that their purpose "will have been served if the reader has been stimulated to try hypnotic techniques as an aid to solving some of the problems . . . in daily practice of the healing arts."

Actually, the book is written for laymen, i.e. individuals unsophisticated and uninformed in the areas of hypnosis, psychopathology, and the treatment of emotional disorders.

While such a book, written for uninitiates, may succeed in "stimulating them to try hypnotic techniques," it fails markedly in alerting the beginner

to the complexities involved in such undertakings. The authors suggest that they understand these issues, yet they continually ignore them: ". . . we know we are generalizing, oversimplifying, and perhaps even allowing a bias of unprovable assumptions to be presented as objective fact . . ."

The book begins with a discussion of the history, theory, and nature of hypnosis, an introduction geared to the level of the World Book Encyclopedia. To cite one example (of many possible) which demonstrates the distortion inherent in oversimplification, one may look to the authors' "discussion" of Freud's use of hypnotic techniques. ". . . using hypnosis as a technique for recovering suppressed memories, Freud later reported that he was unable to obtain deep hypnosis in a significant number of patients and so abandoned this technique." Generalization? Oversimplification? This statement is simply inaccurate! Freud abandoned hypnosis for many reasons, not the least of which was the fact that the "cures" obtained by this method were transitory.

The authors go on to discuss various hypnotic induction techniques followed by an analysis of the importance of the spoken word. From time to time they alert the reader, *en passant*, to some of the significant complications which may be a factor in verbal communications. One sentence usually suffices for this purpose. "When it is recognized that there is room for important misinterpretation of his words, the physician should ask the patient what he understands of the conversation." This "misinterpretation" may not only be the crux of the patient's emotional difficulties, but lies at the core of the doctor-patient relationship. Two psychiatrists like Ulett and Peterson should know better.

Thus, rather than enabling the lay practitioner to become more aware of the significance of the problems with which hypnosis attempts to deal, the authors continually "oversimplify" and distort the importance of the interpersonal relationship so crucial to successful doctoring, to say nothing of the use of a technique such as hypnosis. "All in all, it is the optimistic, positive-thinking person, with a personality that exudes and inspires confidence, who seems best able to help patients with their emotional problems." I won't embarrass the authors by requesting a scientific substantiation of this issue. It would seem, however, that one might obtain a better exposition of this view in *The Power of Positive Thinking*, rather than a book on hypnosis.

In addition to the above shortcomings, the book errs in its presentation of psychopathology. The view the authors present is now outdated by several decades, namely that psychopathologic states are the result of single traumatic events which are too painful for the afflicted person to remember. "The therapeutic problem lies in identifying the traumatic situation. . . ." This view of psychotherapy not only distorts a great deal of the ongoing therapeutic process which occurs today, but also maligns the effect that hypnosis may have in the practice of psychotherapy.

The book ends with a discussion of the use of hypnosis in various other medical specialities, in surgery, obstetrics, dentistry, etc. One can have little quarrel with the view that the potential benefits of hypnosis as an adjunct to these specialities are many, and that the serious and dedicated practitioner may find hypnosis a valuable aid in patient management, care, and recovery. Unfortunately, the rest of the book clouds the issues to such an extent, that the use of hypnosis based on the authors' presentation would appear to disrupt rather than enhance the physician's relationship with his patient, and cause more suffering than it would relieve. Those who are interested in "applied hypnosis" are advised to seek counsel elsewhere.—RICHARD N. WOLMAN, PH.D.

PRACTICAL MANUAL FOR CLINICAL LABORATORY PROCEDURES

Editor, Henry C. Damm, Ph.D., Western Reserve University; Chairman, Advisory Board and Associate Editor, John W. King, M.D., Ph.D., The Cleveland Clinic Foundation (Ohio). The Chemical Rubber Co., Cleveland, O., 44114. 1965. Price: $12.50.

The *Practical Manual for Clinical Laboratory Procedures* is a general survey of clinical laboratory procedures commonly used in the small hospital laboratory. It relies exclusively on manual methods. This book would be valuable for medical technologists in a small hospital. It is of little use as a desk reference for the larger clinical laboratory. This manual would possibly be of use in the physician's office as it explains the nature of physiologic disorders investigated by the various clinical chemistry tests. I would not recommend this manual for purchase and doubt that it will be a valuable addition to the library.—R. H. LAESSIG, M.D.

RADIOLOGIC DIAGNOSIS IN INFANTS AND CHILDREN

By Armand E. Brodeur, M.D., M.Rd., F.A.C.R., Chief Radiologist, Cardinal Glennon Memorial Hospital for Children, St. Louis; Associate Professor of Radiology and Associate Dean, St. Louis University School of Medicine; Medical Director, School of X-ray Technology, St. Louis University; Chairman, Committee on Public Education, American College of Radiology; Consultant to the Division of Radiological Health of the United States Public Health Service and to The Catholic Hospital Association of the United States and Canada. C. V. Mosby Co., St. Louis. 1965. 503 pages. Price: $26.50.

This book is one of several on the subject of pediatric roentgenology which have appeared in recent years. The book is intended, according to the author, to bridge the gap between the clinical years of medical school and the preparation for board diplomacy.

The first chapter considers the technique of differential diagnosis. The remainder of the book is divided into five sections: head and neck, thorax, abdomen, skeleton and integument, and a final short

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Enrollment material will be sent to you to answer questions your patients may have concerning Medicare-PLUS $15,000. Patients may also obtain information by sending a postcard to Wisconsin Physicians Service, Box 1109, Madison.

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HEALTH INSURANCE

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section on the mistreated child. The subject matter is uniformly presented with normal anatomy, abnormalities—congenital and acquired, and pitfalls in diagnosis, being considered in that order.

Descriptions of roentgen findings are generally brief, often being limited to a sentence or two. However illustrations are numerous, well-selected, and of good quality. They add a good deal to the value of the book.

Throughout the book are many helpful hints on the avoidance of errors in diagnosis plus a section at the end of each chapter on pitfalls in diagnosis.

The book should be of value to the resident, especially in the latter part of his training. It should also be helpful to the general radiologist who must do a certain amount of pediatric radiology.—LESTER W. PAUL, M.D.

NEUROLOGICAL SURGERY OF TRAUMA

Prepared and published under the direction of Lt. Gen. Leonard D. Heaton, the Surgeon General, United States Army; Editor-in-Chief, Col. John Boyd Coates, Jr., M.C.; Editor, Arnold M. Meirowsky, M.D., Assistant Clinical Professor, Division of Neurological Surgery, Department of Surgery, Vanderbilt University School of Medicine attending staff member, Vanderbilt University Hospital, St. Thomas Hospital, Mid State Baptist Hospital, and Nashville General Hospital, all in Nashville, Tenn. Civilian Consultant in Neurosurgery to the Surgeon General, U.S. Army. Office of the Surgeon General, Department of the Army, Washington, D. C. 1965. 604 pages. Price: $6.25.

This comprehensive and informative book on neurological surgery of trauma presents an excellent account of the progress made in the management of neurosurgical injuries during the Korean War. It was edited by Dr. Arnold M. Meirowsky, who served as consultant in neurosurgery during the Korean War and was responsible for the outstanding organization in taking care of patients with neurologic injuries that resulted in reducing the mortality rate of patients with craniocerebral trauma to 7.78%, and in penetrating compound wounds of the spinal canal to 3.6%.

Information that is essential to neurosurgery of trauma is given by prominent contributors in 46 chapters of this book. A comprehensive index and excellent illustrations serve as invaluable aids to the reader.

This book is highly recommended to all physicians, medical students, and indeed all those who may be called upon to deal with acute trauma of the nervous system.—MANUCHER J. JAVID, M.D.

* * *

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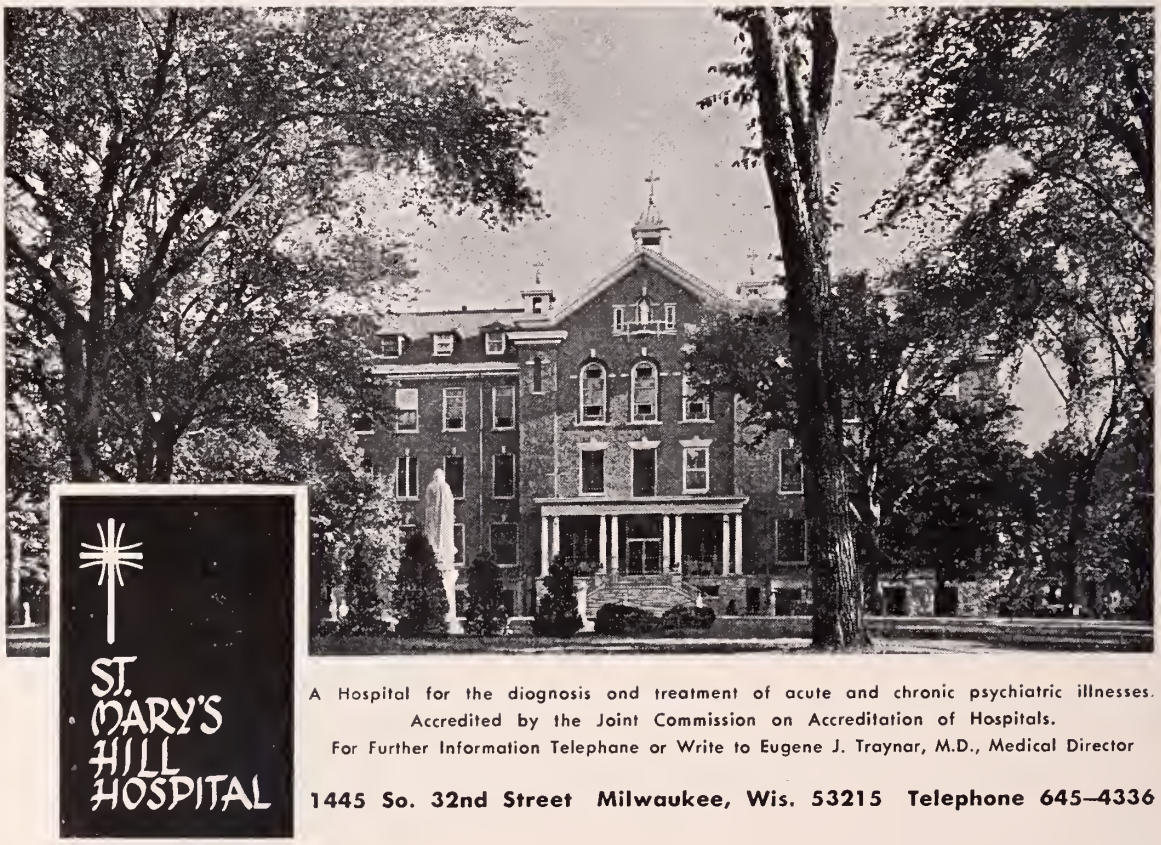

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MEDICAL MEETINGS

POSTGRADUATE COURSES

1967 WISCONSIN

Dec. 6: UW "In-Depth" postgraduate teaching program, Madison.

1968 WISCONSIN

Jan. 15–26: Advanced Maternity Program in Delivery Room Nursing for graduate nurses, Marquette University College of Nursing, Milwaukee.

Jan. 18: UW "In-Depth" postgraduate teaching program, Madison.

Chicago

Feb. 7–8: "Modern Separation Methods of Macromolecules and Particles," University of Wisconsin, Madison.

Feb. 12–23: Advanced Maternity Program in Delivery Room Nursing for graduate nurses, Marquette University College of Nursing, Milwaukee.

Feb. 21: UW "In-Depth" postgraduate teaching program, Madison.

Mar. 4: Postgraduate course, "Hypoglycemias in Infants and Children," sponsored by Marquette University at Children's Hospital, Milwaukee.

Mar. 11: Postgraduate course, "Etiology and Management of Nephrosis in Children," sponsored by Marquette University at Children's Hospital, Milwaukee.

Mar. 11–22: Advanced Maternity Program in Delivery Room Nursing for graduate nurses, Marquette University College of Nursing, Milwaukee.

Mar. 18: Postgraduate course, "Prevention of Mental Retardation," sponsored by Marquette University at Children's Hospital, Milwaukee.

Mar. 21: UW "In-Depth" postgraduate teaching program, Madison.

Mar. 25: Postgraduate course, "Emotional Crises Among Adolescents," sponsored by Marquette University, Milwaukee.

Mar. 27–28: Sports Medicine and General Medicine, University of Wisconsin, Madison.

Apr. 4–5: Wisconsin Anti-Tuberculosis annual meeting, Milwaukee.

Apr. 4–6: Fetus and Newborn, University of Wisconsin, Madison.

Apr. 18–19: Conference for Directors of Nursing in Small Hospitals, University Extension, Marshfield.

Apr. 22–May 3: Advanced Maternity Program in Delivery Room Nursing for graduate nurses, Marquette University College of Nursing, Milwaukee.

May 9–10: Conference for Directors of Nursing in Small Hospitals, University Extension, Madison.

May 14–16: Annual meeting, State Medical Society of Wisconsin, Milwaukee.

June 8: Semi-annual meeting, Wisconsin Society of Pathologists, University Hospitals, Madison.

1967 NEIGHBORING STATES

Dec. 13: "Frontiers in Medicine" series—Shock, The University of Chicago Hospitals and Clinics, Chicago

1968 NEIGHBORING STATES

Jan. 19–20: Course in "New Concepts in Problems of Completed Stroke," Kenny Rehabilitation Institute, Minneapolis, Minn.

Mar. 7–8: Institute of Medicine of Chicago Workshop —The Doctor and His Hospital, Pick-Congress Hotel,

1968 OTHERS

Jan. 10–12: Program on "Current Concepts in Cardiology," Institute for Cardiovascular Diseases, Good Samaritan Hospital, Phoenix, Ariz.

Jan. 11–13: Surgery seminar, Univ. of Miami School of Medicine, Eden Roc Hotel, Miami Beach, Fla.

Jan. 14–18: Second annual meeting of the Society of Cryo-Ophthalmology, Miami Beach, Fla.

Jan. 15–19: Program — Neurology and the Internist, American College of Physicians with Univ. of Miami School of Medicine, Eden Roc Hotel, Miami Beach, Fla.

Feb. 19–21: First of three 1968 sectional meetings in Dallas, Tex., of the American College of Surgeons.

Apr. 22–25: American Industrial Health Conference, Hilton Hotel, San Francisco, Calif.

May 4–9: Annual teaching seminar, International Academy of Proctology, Montreux–Palace Hotel, Montreux, Switzerland.

May 13–17: Annual meeting, Ohio State Medical Association, Cincinnati, the Netherland Hilton Hotel.

Sept. 18–20: Sixth National Cancer Conference, Denver Hilton Hotel, Colo.

Sept. 28–Oct. 3: Western Hemisphere Congress, International College of Surgeons, Honolulu, Hawaii.

Oct. 6–11: XVI Biennial International Congress, International College of Surgeons, Tokyo, Japan.

Oct. 16–26: Scientific and Clinical Seminars in Hong Kong, Manila, and Bangkok, International College of Surgeons.

Oct. 21–25: Annual Clinical Congress, American College of Surgeons, Atlantic City, N.J.

Oct. 26–Nov. 11: Around-the-World Postgraduate Clinics, International College of Surgeons, India, Egypt, Holy Land, Israel, and Greece.

1969 OTHERS

Apr. 21–24: American Industrial Health Conference, Shamrock Hilton Hotel, Houston, Tex.

1968 AMA

Jan. 11–13: First International Conference on Prematurity, Pier 66, Ft. Lauderdale, Fla.

Jan. 18–20: "The Community and Emergency Medical Services" conference, San Francisco Hilton Hotel, Calif.

Mar. 29–30: National Conference on Rural Health, Olympic Hotel, Seattle, Wash.

For listing of other meetings see the JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION.

Industrial Health Conference

The 1968 American Industrial Health Conference will be held April 22–25 in San Francisco, with headquarters at the Hilton Hotel, it has been announced by the Industrial Medical Association and the American Association of Industrial Nurses. This medical–nursing conference which is comprised of the annual meetings of the two sponsoring associations, will bring together approximately 2,500 persons which, in addition to industrial physicians and nurses, will include industrial hygienists, safety engineers, public health officials, military service medical personnel, university faculty members, management representatives and others who have an interest in the health of the working population.

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MEDICAL MEETINGS *continued*

The scientific program, in which many of the nation's experts in the field of occupational health will participate, will be augmented by both scientific and technical exhibits. Postgraduate seminars in selected areas of industrial medical practice also will be presented. Further information about the Conference may be obtained by writing American Industrial Health Conference, 55 East Washington Street, Chicago, Illinois 60602.

UW Symposium on Fetal Medicine

The Department of Pediatrics, University of Wisconsin Medical Center, will present a symposium on "Fetal Medicine" April 4, 5 and 6, 1968, at the Wisconsin Center on the university campus in Madison.

The conference co-chairmen are Drs. Stanley Graven and George Kerr. The program will cover structural, biochemical, endocrine, and genetic aspects of fetal growth and development, fetal diagnosis, fetal and maternal relationship, and extrauterine adaptation. Guest speakers include: Drs. Edward Hon. Robert Greenberg, Thomas K. Oliver, and Alex Robertson.

For further information contact Thomas C. Meyer, M.D., Associate Dean, Department of Postgraduate Medical Education, Room 302, 333 North Randall Avenue, Madison, Wis. 53706.

Florida Surgery Program

The University of Miami School of Medicine will present a postgraduate seminar in surgery Jan. 11–13 at the Eden Roc Hotel, Miami Beach, Fla. The seminar theme is: "Art and Science in the Therapy of Difficult Problems in Surgery."

Registration fee: $100. Further information: Department of Surgery, U. of M. School of Medicine, Jackson Memorial Hospital, P.O. Box 875, Biscayne Annex, Miami, Fla. 33152.

National Conference on Rural Health

"Meeting Health Needs in the '60s and '70s" will be the theme for the 21st national conference on

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rural health sponsored by the Council on Rural Health of the American Medical Association. It will be held March 29–30 at the Olympic Hotel, Seattle, Wash.

Purpose of the meeting will be to explore new needs and report on new developments in comprehensive health care planning, community and emergency medical services, ways to meet health needs—such as use of helicopters—home health services, health manpower—planning and utilization, special problems of accident prevention in rural areas.

Further details: Department of Health Education, Division of Socio-Economic Activities, 535 North Dearborn St., Chicago, Ill. 60610.

First International Conference on Prematurity

The First International Conference on Prematurity, sponsored by the AMA Committee on Maternal and Child Care, will be held Jan. 11–13, 1968, at Pier 66, Ft. Lauderdale, Fla.

An open invitation to attend is being extended to the chairmen and members of all state and county Maternal and Child Care, Infant and Perinatal Mortality Committees; State Health Department Directors of Maternal and Child Health; medical school faculty members in Departments of Obstetrics, Pediatrics, Preventive Medicine and Public Health. Other physicians and representatives of groups interested in the problems of prematurity from throughout the world, are also cordially invited to attend.

The program has been planned around three morning sessions to explore the problems of Prematurity in depth with particular emphasis on obstetrical prevention and pediatric intervention with the ultimate objective of reducing perinatal losses. International speakers will discuss patterns of prematurity, mortality and morbidity factors, pathogenic implications, and national and international newborn programs.

Those interested in receiving additional information about registration for this Conference are requested to write Wesley J. Duiker, Secretary, Committee on Maternal and Child Care, American Medical Association, 535 North Dearborn Street, Chicago, Ill. 60610.

Doctor–Hospital Workshop in Chicago

The Institute of Medicine of Chicago will conduct a two-day workshop on "The Doctor and His Hospital," at the Pick–Congress Hotel in Chicago, Ill., Thursday and Friday, March 7 and 8.

Dr. Paul S. Rhoads, Chairman of the Institute's Board of Governors, indicated that it was the responsibility of this body to thoughtfully examine the increasingly complex problems faced by physicians and patients.

The following panels have been selected:

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2. The Hospital as a Teaching and Research Institution

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6. The Hospital and the Community
7. Alliance of Medicine and Religion in Hospitals
8. The Impact of Federal Funding on Hospital Practice

In keeping with the principal objectives of the Institute, namely, "To promote the study and to encourage the advancement of medicine and allied sciences and their application to human needs," it is hoped that the workshop will result in better answers to the complex interrelationships involved in modern health care than are now available.

American College of Physicians

The American College of Physicians in cooperation with the University of Miami School of Medicine will present "Neurology and the Internist" Jan. 15–19 at the Eden Roc Hotel, Miami Beach.

Further details: Edward C. Rosenow, Jr., M.D., Exec. Dir., ACP, 4200 Pine St., Philadelphia, Pa. 19104.

International College of Surgeons

The International College of Surgeons has the following programs planned for 1968: Western Hemisphere Congress in Honolulu, Sept. 28–Oct. 3; XVI Biennial International Congress in Tokyo, Oct. 6–11; Scientific and Clinical Seminars in Hong Kong, Manila, and Bangkok, Oct. 16–26; and Around-the-World Postgraduate Clinics in India, Egypt, Holy Land, Israel, and Greece, Oct. 26–Nov. 11.

Further information: International College of Surgeons, Hotel and Travel Reservation Office, 230 North Michigan Ave., Chicago, Ill. 60610.

General Practice Review, Colorado

The University of Colorado School of Medicine announces a seven-day postgraduate course, THE FOURTEENTH ANNUAL GENERAL PRACTICE REVIEW, to be held Jan. 14 through 20, 1968, in Denver. This course features one day devoted to each of six major fields of practice: Medicine, Pediatrics, Dermatology, Surgery, Obstetrics and Gynecology, and Trauma. Physicians who do not wish to attend the entire course may register for selected days. The registration fee is $10.00 and the tuition fee for the entire course is $75.00, or $15.00 per day.

A one-day Symposium on Sunday, Jan. 14, 1968, at the Cosmopolitan Hotel in Denver, is entitled IATROGENIC ILLNESS: A PROBLEM OF MEDICAL PROGRESS, and is sponsored jointly by the University of Colorado School of Medicine and the Colorado Academy of General Practice. There are no fees or charges for the Symposium, the luncheon, or other activities of the day. Admission to the Symposium

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is by invitation only. Invitations and detailed programs for both the Symposium and the General Practice Review postgraduate course may be obtained by writing to: The Office of Postgraduate Medical Education, University of Colorado School of Medicine, 4200 East Ninth Avenue, Denver, Colo. 80220.

Surgery of the Hand, Colorado

The University of Colorado School of Medicine announces a four-day postgraduate course on SURGERY OF THE HAND, to be held Feb. 20 through 23, 1968, in Denver.

Registration and tuition fees are $80.00. For further information and a detailed program, write to: The Office of Postgraduate Medical Education, University of Colorado School of Medicine, 4200 East Ninth Avenue, Denver, Colo. 80220.

AMA Schedules National Conference On Emergency Medical Services

"The Community and Emergency Medical Services" will be the theme of a national conference sponsored by the American Medical Association January 18–20, 1968 at the San Francisco Hilton Hotel, San Francisco, Calif.

During the 2½ day program all aspects of a community's emergency medical services system will be discussed in terms of identification, coordination, and implementation. This system includes: first aid and emergency care, transportation of the ill and injured, emergency communications, and emergency facilities.

Special emphasis will be placed upon the development of Community Councils on Emergency Medical Services and ways and means of financing the community's emergency medical services system. Roles of the U. S. Department of Transportation, Public Health Service, state government and organized medicine also will be discussed.

The conference is open to all persons involved or interested in their community's emergency medical care. This includes physicians; allied health personnel; hospital administrators; providers of ambulance services; public safety officials—police, fire and sheriff; government officials—local, county and state; representatives of service organizations; planners; educators; and private citizens. A cross section of the various national leaders of the above groups will be featured on the conference program.

An added highlight will be industrial and organizational exhibits related to the various aspects of the emergency medical services system.

For further information, write to: American Medical Association, Department of Hospitals and Medical Facilities, 535 North Dearborn Street, Chicago, Illinois 60610.

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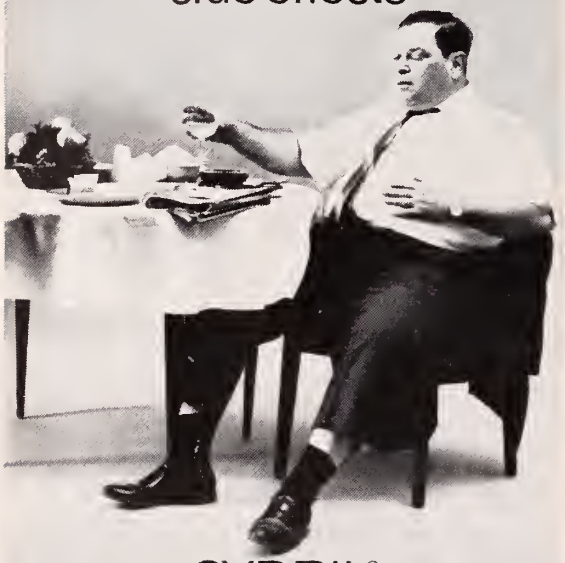

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A Special Annual Meeting Feature

MEDICAL ART SALON

SPONSOR: The Woman's Auxiliary to the State Medical Society of Wisconsin

CO-CHAIRMEN: Dr. and Mrs. Lawrence Larsen and Dr. and Mrs. Raymond Zastrow, Milwaukee

MILWAUKEE AUDITORIUM . . . MAY 13–16, 1968

Sculptures and Paintings (watercolors and oils only)

WHO MAY EXHIBIT: Any member of the State Medical Society of Wisconsin or his wife.

LIMITED ENTRIES: Up to 3 entries per person.

DEADLINE FOR ENTRIES: All notifications of "Intent to Exhibit" must be received on or before April 1, 1968. (Early notification will be appreciated, so that proper facilities for the entire exhibit can be planned in advance. Mail your entry blank below as soon as possible.)

REQUIREMENTS: (1) All pictures must be framed with wire and screw eyes attached. (2) Works of sculpture must not exceed 24 inches in height. (3) All entries must be delivered to the Dressing Room on the east side of the stage of Bruce Hall, Milwauwkee Auditorium between 8:00 a.m. and 10:00 a.m., Monday, May 13, and must be picked up in the display area between 3:30 p.m. and 5:00 p.m., Thursday, May 16.

JUDGING AND AWARDS: Ribbons for first, second, and third places in each of the three categories (sculpture, watercolor painting, oil painting) will be awarded, plus a "popularity award" based on votes of all those who view the Art Salon.

LIMITED LIABILITY: The submitter must assume full responsibility for work submitted, but every care against damage or theft will be exercised. Guard will be provided during the course of the display.

NOTIFICATION OF INTENT TO EXHIBIT

Mail to Dr. and Mrs. Lawrence Larsen, 6520 N. Atwahl Drive, Milwaukee, Wis. 53209, BEFORE APRIL 1, 1968.

I plan to submit the following entry or entries for the 1967 MEDICAL ART SALON at the Milwaukee Auditorium, May 13–16.

My entry, or entries, will be:

(1) Painting ____ Title _____ ☐ watercolor ☐ oil size _____" wide and _____" deep

(2) Painting ____ Title _____ ☐ watercolor ☐ oil size _____" wide and _____" deep

(3) Painting ____ Title _____ ☐ watercolor ☐ oil size _____" wide and _____" deep

(1) Sculpture __ Title _____ size _____" wide and _____" high

(2) Sculpture __ Title _____ size _____" wide and _____" high

(3) Sculpture __ Title _____ size _____" wide and _____" high

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FIFTH ANNUAL WISCONSIN WORK WEEK OF HEALTH

State Medical Society of Wisconsin

OCTOBER 16-20, 1967

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Statewide Interest High for Annual Week of Health

More than 2,000 visitors attended the fifth annual Wisconsin Work Week of Health at State Medical Society headquarters in Madison, Oct. 16–20. The event was sponsored by the State Medical Society and cosponsored by over 30 state and national organizations.

Work Week of Health is the only event of its kind in the nation: a five-day program, open to the public at no charge, which brings authorities in health, religion, industry, welfare, and education to discuss the goals and problems of the continued good health of Wisconsin residents.

Each of the five days was devoted to a special subject.

On Monday, Oct. 16, speakers and panelists were concerned with traffic safety and rescue. Included were detection of the medically impaired driver; drugs and driving; special accident problems of the motorcycle boom; and how to improve rescue efforts.

Tuesday, Oct. 17, covered Wisconsin's homes for the aged, nursing homes, extended care facilities, and the effects of the federal Medicare program on these institutions.

On Wednesday, Oct. 18, the topic was life extension, emphasizing the scientific, philosophical, and ethical considerations of modern methods which can postpone death but cannot restore the patient to health.

The nurse and her increasingly important role in society were highlighted Thursday, Oct. 19. Discussion ranged from physician–nurse relationships and patient care to the transition of nursing education and the liabilities of the nurse and physician to the patient.

The state's rehabilitation facilities for the mentally ill and retarded were discussed on the final day, Friday, Oct. 20. Panel discussions opened the day with topics entitled "First Friends," "Halfway Houses," "Day Programs," and "Community Mental Health Clinics." Other topics included the role of work in the rehabilitation of the mentally handicapped and comprehensive community mental health centers in Wisconsin.

Stethoscope Exhibit Dedicated at Wisconsin Work Week of Health

A collection of stethoscopes—a traditional symbol of medicine for 150 years—was dedicated on Wednesday, Oct. 18, at the headquarters of the State Medical Society.

As part of the health education program of the Charitable, Educational and Scientific Foundation of the Society, the dedication was included in the activities of the fifth annual Wisconsin Work Week of Health. The exhibit, as well as the five-day meeting, was open to the public at no charge. All of the stethoscopes in the exhibit have been donated to the State Medical Society.

EXAMINING THE STETHOSCOPE EXHIBIT, dedicated Oct. 18 at State Medical Society headquarters, are Dr. Edward K. Ryder, Jr. of Madison, president of the Wisconsin Society of Internal Medicine; Dr. Austin Smith, chairman of the Board, Parke, Davis & Company, Detroit, Mich.; Dr. W. D. James of Oconomowoc, president-elect of the State Medical Society; and Dr. E. J. Nordby of Madison, vice-chairman of the Council.

During dedication ceremonies, Dr. W. D. James, president-elect of the State Medical Society, made the presentation to Dr. W. D. Stovall, president of the CES Foundation. Responding to Doctor Stovall's acceptance were Dr. Edward K. Ryder, Jr., president of the Wisconsin Society of Internal Medicine, and Dr. Austin Smith, chairman of the Board of Parke, Davis & Company.

The Wisconsin Society of Internal Medicine donated funds for the original exhibit and Parke, Davis & Company commissioned the Robert Thom painting in its series "Great Moments in Medicine."

Although the stethoscope is only 150 years old, its importance in medicine has been so great that for many people it symbolizes the medical profession.

Also on display during the Wisconsin Work Week of Health was a collection of Aesculapian staffs, which are formed from a variety of materials ranging from gold and silver coins to colorful buttons; from mother-of-pearl to one formed entirely of varicolored pills, the whimsical work of an artistic Wisconsin physician. Many are imbedded or mounted on backgrounds; others are actually carved walking sticks, including one of unknown origin, bearing German military insignia and the names of three men.

Contributors of the stethoscopes are: Donald L. Richardson, Chicago, Ill.; Dr. Sidney M. Barth, Brooklyn, N. Y.; Dr. Ruth Blount Bennett, Wilmette, Ill.; Dr. Harwin J. Brown, Winfield, Kan.;

Mrs. John Collins, Kendall, Wis.; Dr. Theodor Friedrichs, Astoria, L. I., N. Y.; Dr. F. G. Gaenslen, Milwaukee, Wis.; Dr. F. H. Goetsch, Spooner, Wis.; Dr. C. A. Harper, Madison, Wis.; Dr. Elgie M. Houghton, Lancaster, Wis.; Roche Laboratories, Nutley, N. J.; Dr. Victor Jacobsen, Troy, N. Y.; Dr. James B. Luckie, Pasadena, Calif.; Dr. M. E. Sanders, Redfield, S. D.; Dr. Lawrence Shinabery, Fort Wayne, Ind.; Mrs. John Towle, Ardmore, Pa.; and Mrs. Milt Greenslet, Madison, Wis.

Grave of Early Society President Restored at Special Ceremony

The grave of one of the area's first physicians who served as mayor of Mineral Point in 1876, was restored at a special ceremony in Mineral Point, Oct. 12.

A new gravestone and bronze plaque were erected to honor Harmon Van Dusen, M.D., in the old city cemetery.

The occasion was sponsored by the Charitable, Educational and Scientific Foundation of the State Medical Society. It coincided with Mineral Point's project to restore the old cemetery, which contains the graves of the city's first white settlers and dates back to the mid 1830s.

Born in Connecticut in 1803, Doctor Van Dusen began "reading medicine" at 18, and received a medical diploma in New York in 1826. He spent the next ten years at Jefferson Medical College in further study.

After practicing in New York, he moved to Milwaukee in 1847, but moved on to Mineral Point after a few months.

TAKING PART IN THE DEDICATION of Doctor Van Dusen's grave site at Mineral Point are: Mineral Point Mayor George Branger; Dr. W. D. Stovall of Madison, president of the CES Foundation; Dr. W. D. Hamlin of Mineral Point, CES Foundation trustee and master of ceremonies; and Pastor Alfred J. Wittmann. Refurbishing the grave included planting of evergreens around the Van Dusen plot.

Doctor Van Dusen was one of the charter members of the Territorial Medical Society, and served as State Society president for several years in the late 1860s. He remained active in medicine and civic affairs until his death in 1885.

Mineral Point records indicate the site of the cemetery was chosen in 1830, when a miner "was wont to remark that when he died he desired to be buried beneath the 'big tree' on the hill."

"This being a sightly place for a cemetery, others were buried there and so close to the big tree were the graves located that it soon died from injuries received from digging."

PROUDLY DISPLAYING THE First Annual Health Information Award of the State Medical Society, presented to the Mobil Oil Company, Oct. 16, are Dr. Milford O. Rouse of Dallas, Tex., president of the American Medical Association; J. D. Elgin of New York City, Mobil advertising manager; Dr. Joseph Devitt, of Milwaukee, chairman of the State Medical Society's Commission on Health Information; and Dr. Harold J. Kief, president of the State Medical Society.

State Medical Society Honors Mobil Oil for Traffic Safety Campaign

The State Medical Society presented an award to Mobil Oil Company Oct. 16 for its two-year advertising campaign to promote traffic safety.

At the conclusion of a day-long public program on traffic safety and rescue of accident victims, the Society presented Mobil with its National Health Information Award, established to "honor private industry, agencies or individuals who utilize public news media in an outstanding manner to promote health and safety measures to the American people."

The award was originated by the Society's Commission on Health Information. Dr. Milford O. Rouse, Dallas, president of the American Medical Association, made the presentation.

A spokesman for Mobil said that the company has spent more than $6,500,000 on the safety campaign since January 1966. The campaign has ap-

peared on 167 television stations; on radio from coast to coast; and in 153 newspapers, with a combined circulation of more than 35,000,000.

The Oct. 16 program on traffic safety was the first in Wisconsin Work Week of Health, The State Medical Society's annual five-day free public symposium, with each day devoted to a different health subject.

Presidents Room at Society Headquarters Dedicated

The Presidents Room at State Medical Society headquarters was dedicated in formal ceremony Thursday evening, Oct. 19, before a group of 100 past presidents, Society councilors and officers, relatives and friends. Unveiling of a plaque containing individually etched pictures of the past presidents of the State Medical Society followed a dedicatory address by the Society President, Dr. Harold J. Kief of Fond du Lac. Dr. H. Kent Tenney, representing the past presidents, gave the response in which he quoted from a presidential address of his grandfather, Dr. John Favill, who was the Society's president in 1871–1872. Dr. E. J. Nordby, president of

THE UNVEILING OF A PLAQUE containing individual plates identifying the Society presidents took place at the dedication of the Presidents Room Oct. 19 at State Medical Society headquarters in Madison. Society president, Dr. Harold J. Kief of Fond du Lac (left) and a past president, Dr. H. Kent Tenney of Madison (right) performed the unveiling. The plaque has been hung at the entrance to the Presidents Room.

Of the 108 presidents, only 5 lack a picture. These are: Dr. John Mitchell of Janesville who served in 1855–1856; Dr. Clark G. Pease of Janesville, 1857–1859; Dr. Solomon Blood of Rochester, 1861–1862; Dr. Ezra M. Rogers of Hartford, 1889–1890; and Dr. Herman Reineking of Milwaukee, 1898–1899. The Society would appreciate receiving any information which might lead to the location of their pictures.

MEETINGS AND SPECIAL EVENTS HELD AT THE STATE MEDICAL SOCIETY "HOME" DURING THE MONTH OF OCTOBER 1967

3 Board of Trustees, Dane County Medical Society
3 Madison Urology Society
3 Madison Anesthesiology Society
4 Madison Academy of Internal Medicine
6 Commission on Scientific Medicine, SMS
7 Program Planning Committee, North Central Conference Blue Shield Plans
7 District X, National Blue Shield Plans
8 District X, National Blue Shield Plans (Madison)
10 Examination for Trained Practical Nurses, State Division of Nursing
10 Annual Meeting, Dane County Medical Society
11 Ad Hoc Committee on Nurse Practice, SMS and others
11 Council on Health (Madison)
12 Dedicaton of Marker at Dr. Harmon Van Dusen Grave Site, (Mineral Point), SMS
12 Madison Radiology Study Group
13 Industrial Health Clinic, SMS Committee on Occupational Health (Wausau)
15 Division on Nervous and Mental Diseases, SMS
16 Wisconsin Work Week of Health, SMS
16 Commission on Health Information, SMS
16 Commission on Safe Transportation, SMS
16 Councilors and Officers, SMS
16 Dinner for AMA President, Dr. Milford O. Rouse
16 Presentation of Mobil Oil Company Award for Traffic Safety Campaign, SMS
17 Wisconsin Work Week of Health, SMS
18 Wisconsin Work Week of Health, SMS
18 Finance Committee of Council, SMS
18 Dedication of Stethoscope Exhibit, SMS
19 Wisconsin Work Week of Health, SMS
19 Dedication of Presidents Room, SMS
19 Commission on Hospital Relations and Medical Education, SMS
20 Wisconsin Work Week of Health, SMS
25 Planning Committee, Wisconsin Regional Medical Program
25 Ad Hoc Committee on The Medical Practice Act, SMS
26 Commission on Public Policy, SMS
28 North Central Conference, Blue Shield Plans (St. Paul)
29 North Central Conference, Blue Shield Plans (St. Paul)

Meetings not held in the Society "Home" but which have a direct relationship are printed in italics, with the location in parentheses.

DISTINGUISHED GUESTS AT THE DEDICATION of the Presidents Room at State Medical Society headquarters Oct. 19 are the past presidents and officers of the State Medical Society (left to right): Dr. Harold J. Kief, Fond du Lac, president; Dr. E. L. Bernhart, Milwaukee; Dr. Frank E. Drew, Milwaukee; Dr. Arthur J. McCarey, Green Bay; Dr. John H. Houghton, Wisconsin Dells; Dr. Ralph P. Sproule, Milwaukee; Dr. W. D. James, Oconomowoc, president-elect; Dr. Edmund D. Sorenson, Elkhorn; Dr. W. D. Stovall, Madison; Dr. Karl H. Doege, Marshfield; Dr. Harry E. Kasten, Beloit; Dr. Nels A. Hill, Madison; Dr. Joseph C. Griffith, Milwaukee; Dr. H. Kent Tenney, Madison; Dr. L. O. Simenstad, Osceola; and Dr. W. P. Curran, Antigo. Past presidents who were unable to attend are: Dr. W. J. Egan, Milwaukee; Dr. Matthew A. McGarty, La Crosse; Dr. Gunnar Gundersen, La Crosse; Dr. William B. Hildebrand, Menasha; and Dr. Leif H. Lokvam, Kenosha.

the SMS Realty Corporation and vice-chairman of the Council, was the master of ceremonies.

The Presidents Room is located on the upper level of the State Medical Society's West Wing which was built in 1962. It can accommodate 250 persons comfortably, including the Society's House of Delegates. The room is furnished with long slim tables and cushioned chairs in shades of brown, rust, yellow, and green. It can be divided into smaller meeting rooms, and is adjoined by a small service kitchen which facilitates catered box lunches for large groups and buffet-type service for smaller groups.

Use of the Presidents Room is increasingly regular, and many groups are brought to Society headquarters with a consequent ability to demonstrate by exhibit and by publications the scope of the Society's public health and other interests. Currently the Society's exhibit of Aescupalian Staffs adorns the walls. Some thousands of persons yearly can be expected to visit the Presidents Room with functions such as the Wisconsin Work Week of Health.

Woman's Auxiliary to SMS

Seven Wisconsin members of the Woman's Auxiliary to the State Medical Society and its staff secretary participated in a four-day intensive leadership conference at the Drake Hotel in Chicago, Oct. 8–11.

The conference, aimed at establishing or expanding communitywide auxiliary programs dealing with mental health, sex education, home-centered health care, health manpower shortage and MED-AID, an international communication system for expediting medical information via ham radio, was attended by more than 200 members of the Woman's Auxiliary to the American Medical Association, sponsor of the conference.

Attending all or part of the conference were the following: Mrs. Donald Britton, Madison, president; Mrs. James Sargent, Milwaukee, president-elect; Mrs. A. E. Schultz, Madison, chairman of AMA-ERF; Mrs. N. M. Clausen, Madison, editor of BADGER DOCTOR'S WIFE; Mrs. W. G. Meier, Sheboygan, chairman of International Health; Mrs. Max Smith, Madison, chairman of the North Central Region on International Health; Mrs. J. J. Levin, Wood, publicity chairman; and Mrs. Leona K. Chesemore, Madison, staff secretary.

Wisconsin Association of Professions

A meeting of the Board of Directors of the WAP was held Sept. 12 at State Medical Society headquarters in Madison. Among organizational matters discussed, it was reported that the number of individual members had increased to 224 with the chartering organizations represented as follows:

Wisconsin Chapter of the American Institute of Architects	20
Wisconsin Society of Certified Public Accountants	4
Wisconsin State Dental Society	31
Wisconsin Society of Professional Engineers	15
State Bar of Wisconsin	6
State Medical Society of Wisconsin	133
Wisconsin Pharmaceutical Association	3
Wisconsin Education Association	1
Wisconsin Veterinary Medical Association	11
TOTAL	224

Wisconsin Association of Professions was formed earlier this year to promote the interests of the professions and their members in the State of

Wisconsin. It is WAP's purpose to be an effective step toward greater public education concerning the contributions which professional men and women make in society. Further, it is hoped that it will be a stimulus to young people to seek out professional careers; a means of upholding the caliber of those drawn to the professions and of aiding them in their educational pursuits; and a unifying force toward common goals as professional people and active citizens of Wisconsin.

Individual membership is encouraged by the nine chartering organizations. Annual dues is $10. Applications and further information may be obtained by contacting Dr. H. J. Kief of Fond du Lac, Dr. Herman W. Wirka of Madison, or the State Medical Society, Box 1109, Madison, Wis. 53701.

WISCONSIN WORK WEEK OF HEALTH, OCT. 16–20, 1967

Lists "Five I's" as Major Causes of Traffic Deaths, Accidents

A Sheboygan physician has listed the five causes of traffic accidents as immaturity, inattention, impatience, intoxication or incapacity.

Dr. James L. Weygandt of Sheboygan Falls, chairman of the State Medical Society's Commission on Safe Transportation, said the driver is the chief cause of traffic fatalities and is usually affected by one or more of these factors.

Doctor Weygandt spoke at the first day of Wisconsin Work Week of Health, Oct. 16–20, on a program devoted to traffic safety and rescue of accident victims. He included in the area of intoxication the effect of drugs or medications, as well as carbon monoxide from smoking. Incapacity, he said, can include mental illness or temporary depressions.

The physician said that reluctance to support driver retesting stems from the fear "that there will be overzealous use of this police power and unjustified refusal of renewal, particularly as it involves the older drivers." He said that it is now believed in medical circles that there is no evidence that age alone is a justifiable criterion for definition of ability to drive safely.

He said that many permanent physical handicaps are compensated for by the "extreme adaptability of the human organism" so that the driver can function in complete safety with the proper equipment on his car. Other handicaps, such as stages of blindness or lapses of consciousness, indicate incapacity for safe driving. Doctor Weygandt criticized driver license renewal by mail. "Provisions should be made in the licensing and relicensing procedures for screening of all applicants so that those whose physical or functional capacities are questioned may be referred for appropriate testing," Doctor Weygandt said.

Society Must Guide M.D.'s In Determination of When Dying Patient Allowed to Die

Modern science, which now permits the dying to be kept alive almost indefinitely in a "vegetable state" will make it necessary for society to decide when the physician may be permitted to end treatment and permit the patient to die, a Chicago physician has said.

Dr. J. Ernest Breed said that society "must decide what is moral and what is ethical, since the mores of a society are always in a state of flux and vary with time, place and circumstance."

Doctor Breed spoke in Madison at a public meeting during Wisconsin Work Week of Health, Oct. 16–20, sponsored by the State Medical Society.

He cited methods of modern surgery, life extension techniques and conflicting definitions of when death actually takes place, as posing a moral problem for the patient's family and his physician.

"Clinical death," Doctor Breed said, is defined as "that time when spontaneous respiration has ceased and the heart has stopped beating; 'biological death' is the death of the tissues."

"Should the doctor delay biological death after clinical death by keeping tissues alive with stimulants, respirators, and other resuscitative devices?" Doctor Breed asked. "If he does, can he at any time discontinue the artificial means of preserving a semblance of life?"

Surgical techniques which permit organ transplant add to the complexity of the problem, Doctor Breed said.

He cited a recent ruling by England's Minister of Health which would permit hospital medical staffs to decide secretly which terminal patients should be allowed to die and which it should try to resuscitate. This directive, he said, might include some who could be rehabilitated.

"Rules concerning the termination of such a life should be laid down by society as a whole and not in secrecy by anyone," Doctor Breed said.

Rural Areas Have Highest Traffic Fatality Record: Can Be Corrected

Of the 53,000 traffic deaths in the nation in 1966, 70% occurred in rural areas in communities of 2,500 people or less, according to a medical authority on transportation of the injured.

Dr. Joseph D. Farrington of Minocqua, former president of the Chicago Orthopaedic Society and a member of the committee on trauma of the American College of Surgeons, spoke in Madison before a public audience for Wisconsin Work Week of Health, Oct. 16–20. Doctor Farrington's subject was emergency care and transportation of the critically ill and injured.

The physician said that most victims who die at the scene of a rural traffic accident have been there an hour or more at the time of death. He also cited as factors increasing the death rate the distance to be traveled for treatment, poor care at the accident scene and during transportation.

The physician said that volunteer ambulance services in rural areas is the best solution to the problem of rural accident deaths. For the most part, inadequate ambulance services in these areas is due to lack of financing, Doctor Farrington said.

He said that volunteer fire departments, properly trained, can provide excellent care and avoid the cost of a separate ambulance service.

Doctor Farrington stated that while morticians provide the greatest number of ambulances in the nation, "This service is usually operated at a loss and many are discontinuing it daily."

An authoritative body must be responsible for regulation of ambulance service, Doctor Farrington said, but an advisory council in each community can help solve many problems. He suggested the council be made up of representatives of the mayor, fire chief, police chief, medical society, hospitals, civic organizations, red cross, ambulance companies, industry, PTA's and other groups depending on the size of the community.

The physician suggested that more than one type of vehicle be employed for transportation, emergency care and transportation, and rescue.

He said the public must be educated to the necessity for improved and adequate ambulance services and "made aware that proper ambulance service is going to cost money." The medical profession, Doctor Farrington said, must take a larger role in training emergency personnel, but stressed that this is not to be merely first aid training, which should be taught by others. Finally, he said the professional emergency attendant must be better educated, with better pay to improve the field's status.

FURTHER REPORTS of speakers at the Fifth Annual Wisconsin Work Week of Health will be published in future issues.

Wisconsin Physicians Service Special Open Enrollment for Medicare-PLUS $15,000—A Blue Shield Major Medical Contract for Wisconsin Residents 65 and Over

Wisconsin Physicians Service is offering a special open enrollment for its Major Medical contract for senior citizens. The contract, called Medicare-PLUS $15,000, will pay up to $15,000 to fill gaps and extend benefits offered by the Federal Medicare Program.

This contract was one of the first of this type offered in Wisconsin.

Anyone 65 or over can apply during the open enrollment, September 1-December 31, 1967. No health examination is required. Benefits for pre-existing conditions are covered after the first six months, if such conditions are not treated during the first six months following the effective date. The effective date of the Medicare-PLUS $15,000 contract is January 1, 1968 for those who enroll before December 31, 1967 and already have Federal Medicare Part B.

The premium for the Medicare-PLUS $15,000 plan is $7.95 per month.

The Medicare-PLUS $15,000 contract offers the following advantages:

- ____ $15,000 benefit for each insured illness and each insured injury for a 4-year benefit period. It extends benefits offered by Federal Medicare Hospital and Medical Plan Part A and B.
- ____ Full payment up to contract maximums for covered expenses when Federal Medicare benefits are exhausted.
- ____ Deductible and co-insurance under the Federal Medicare Program are payable. The only exclusions are those expenses actually paid or payable under Federal Medicare and items or services excluded from Federal Medicare coverage.
- ____ There is a $50 annual deductible, which is refunded when covered expenses exceed $50. Out-of-pocket expenses paid under the Federal Medicare Program apply to this deductible.
- ____ Policy is guaranteed renewable for life . . . rates may be changed only if rates of all members of the subscriber class are changed.
- ____ Hospital and nursing home days are unlimited, as are drugs recommended by a physician (including self-administered), inhospital private duty nurse, and doctor's home and office calls.
- ____ There is a 365-day lifetime benefit for inpatient psychiatric hospital care. Medical care for mental, psychoneurotic and personality disorders is paid up to 50% or $1,000, whichever is lesser.
- ____ Benefits are paid in addition to policies payable from other insurers.

WPS offered the Century Plan for senior citizens of Wisconsin from 1959 until July, 1966, when it was replaced by the Medicare-PLUS $15,000 contract. The Century Plan was discontinued in July, 1966 because it duplicated many benefits which are now being paid under Federal Medicare.

WPS home offices are in Madison, Wisconsin, 330 East Lakeside Street. Further information on the WPS Medicare-PLUS $15,000 contract may be obtained by writing to Box 1109 at that address.

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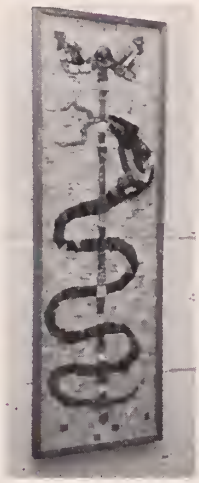

THANKS to Dr. Ray M. Moose of Laguna Hills, California, for donating his original sculpture of the "Symbol of Aesculapius." This fine art-piece has been added to the Society's collection of Aesculapian Staffs.

Doctor Moose, who retired from active medical practice only three months ago at the age of 76, considers himself an amateur sculptor, although he is a former vice-president of the American Physicians' Art Association, and won a silver medal in sculpture at the AMA Convention in 1961 in New York. He also has won a number of ribbons in sculpture in California, the last being the Jurors' Award in 1966 at the All California Art Exhibit.

A highlight of Doctor Moose's efforts at sculpture was when a group of San Bernardino physicians hired a local art instructor to teach them sculpture. Their efforts culminated in an all-physicians' art exhibit which received considerable recognition in Southern California. Now, in his retirement, Doctor Moose has signed up for another art course in one of the club houses in the Laguna Hills Leisure World where he resides. This is but another example of the Society's recognition of "Hobbies for Health."

CONTRIBUTIONS OF ARTIFACTS AND MEMORABILIA ARE ENCOURAGED. IF YOU CAN PERSONALLY CONTRIBUTE, OR YOU KNOW OF SOMEONE WHO WOULD LIKE TO, PLEASE INFORM THE SOCIETY OFFICE. ARRANGEMENTS CAN BE MADE FOR PICKUP OF ITEMS IF NECESSARY.

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NEWS OF WISCONSIN PHYSICIANS

Dr. Plueddeman Elected to AAGP

Dr. Paul M. Plueddeman, Markesan, recently was elected to membership in the American Academy of General Practice.

Dr. Tuffli Joins Staff

Dr. Gordon A. Tuffli, Madison, recently joined the staff of the Jackson Clinic. He graduated from the University of Wisconsin Medical School and serves as a clinical instructor in general pediatrics and pediatric endocrinology at University Hospitals.

West Allis Memorial Adds Doctors

West Allis Memorial Hospital recently added five new doctors to its staff. They are: Drs. Marvin D. Miller, Robert D. Bahr, *Robert Toohill*, *Eugene Lathers*, and *Dwight Brown*. Doctor Miller completed his medical education at the University of California in Los Angeles and served his internship at University Hospitals in Madison. Doctor Bahr graduated from George Washington University Medical School and has been in practice in Danville, Ill., for the past five years. Drs. Toohill, Lathers, and Brown received their medical degrees from the Marquette School of Medicine, interned at Presbyterian–St. Luke's in Chicago, Lutheran Hospital of Milwaukee and Columbia Hospital, Milwaukee, respectively.

Dr. Peden Joins Staff

Dr. John K. Peden, West Salem, recently joined the staff of the West Salem Clinic. His home is Sanquahar, Scotland, where he was a graduate of Edinburgh University. Doctor Peden interned at Middlesex Memorial Hospital in Middleton, Conn., and had a private practice in Owen, Wis. He also served aboard the hospital ship, HOPE, and the past two years have been spent doing postgraduate study in Edinburgh.

Dr. Browell Joins Marshfield Clinic

Dr. John N. Browell, Jr., Marshfield, recently joined the staff of the Marshfield Clinic. Doctor Browell graduated from the Maryland Medical School, took his internship at Great Lakes Naval Hospital, and did four years of residency work at Henry Ford Hospital in Detroit.

Drs. Heersma and Johnson Guest Speakers

Dr. James Heersma and *Dr. Sidney Johnson* of The Marshfield Clinic recently were the guest speakers at the annual fall meeting of the Northern Wisconsin Dietetic Association, held in Wausau.

Dr. Bronson Elected President

Dr. Frederick Bronson, Portage, recently was elected president of the Columbia County Unit of the American Cancer Society, at the quarterly board meeting held in Portage.

Physicians whose names appear in italics are members of the State Medical Society.

Dr. Wilkinson Awarded Certificate

Dr. H. E. Wilkinson, Tomah, recently was honored by the Veterans Administration Office in Washington, D. C. for his completion of 25 years of government service. He is the director of the Tomah VA Hospital.

Dr. H. F. DeMorest Guest Speaker

Dr. H. F. DeMorest, Menasha, recently was the guest speaker for the members and guests of "Who's New Club" in Oshkosh. Doctor DeMorest presented a talk entitled "How to Keep Your Husband Alive."

Dr. Russo Heads Sanatorium Association

Dr. John G. Russo, Kaukauna, superintendent of Riverview Sanatorium, recently was elected president of the Wisconsin Sanatorium Superintendents Association at its annual convention.

Dr. Marcich in Europe

Dr. Zivko Peter Marcich, Cudahy, recently left for an extended tour through Europe and to visit the island of RAB, off the Dalmation coast, where Doctor Marcich was born. Doctor Marcich plans to return to Cudahy in mid-January where he will resume his practice.

Dr. Hirschboeck Guest Speaker

Dr. John S. Hirschboeck, Milwaukee, coordinator of the Wisconsin Regional Medical Program, recently spoke before a meeting of the Marathon County Medical Society.

Dr. Baldwin Elected Chief of Staff

Dr. Robert C. Baldwin, Watertown, was elected chief-of-staff at Watertown Memorial Hospital for the coming year. Others elected were: *Dr. John Becker*, vice-chief-of-staff, and *Dr. Margaret Von Gradulewski*, secretary–treasurer.

Dr. Edwards Retires

Dr. Albert C. Edwards, Racine's city health commissioner, recently retired after 22 years as the city health officer. Doctor Edwards has been active in the Racine chapter of the American Red Cross, Community Chest, Guidance Clinic, Family Service, Infantile Paralysis Chapter, and the Tuberculosis Association. He is also lecturing once a week to a class in Marquette's School of Nursing. Doctor Edwards received his degree in medicine at the University of Nebraska and a master of public health degree from Johns Hopkins University.

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PHYSICIAN NEWS *continued*

Drs. Hansen and Toyama Join Marshfield Clinic

Drs. Raymond L. Hansen, Colby, and William M. Toyama, Marshfield, recently joined the staff of the Marshfield Clinic. Doctor Hansen graduated from the University of Wisconsin Medical School in 1952 and practiced in Colby for 10 years prior to taking his residency work in pediatrics and pediatric allergy at the Mayo Clinic. Doctor Toyama graduated from the University of Michigan Medical School in 1957, served in the United States Navy Medical Corps until 1961 and did resident surgery work at Virginia Mason Hospital in Seattle, Roswell Memorial Institute in Buffalo, New York, and six months at the Buffalo Children's Hospital prior to his appointment at Marshfield.

Dr. Balistrieri Guest Speaker

Dr. James J. Balistrieri, Milwaukee, recently spoke on mental health in the classroom at a two-day Catholic teacher's institute at the Auditorium in Milwaukee.

Dr. Puchner Speaker at Heart Lecture Series

Dr. Thomas C. Puchner, Milwaukee, recently spoke at the opening session in a series on "Recipes for Healthy Hearts" sponsored by the health occupations division of the Milwaukee Vocational, Technical and Adult Schools and the Wisconsin Heart Association.

American College of Surgeons Inducts Fourteen

Fourteen Wisconsin physicians recently became fellows of the American College of Surgeons. They are: *Juan C. Beltran,* Beloit; *Charles M. Ihle,* Eau Claire; *Larry C. Carey,* Elm Grove; *Joseph C. Devine,* Fond du Lac; *Roman Bilak,* Kenosha; *Charles E. Yale,* Madison; *Manuel M. Aquino, Donald J. Chrzan, William E. Reifenrath, William J. Schulte, Jr.,* and *Wilbert Viviott,* Milwaukee; *William P. Chalos,* Wauwatosa; Wolfgang O. W. Dietsche, Wisconsin Rapids, and *Bruce F. Stengel,* Wood.

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COUNTY SOCIETY PROCEEDINGS

MILWAUKEE

The Medical Society of Milwaukee County sponsored a symposium on air pollution and health Oct. 18 at the Holiday Inn–Central, Milwaukee. Among the speakers were Dr. Warren Winkelstein, Jr., professor of preventive medicine at the State University of New York at Buffalo; *Dr. E. R. Krumbiegel*, Milwaukee health commissioner; Fred R. Rehm, deputy director of the county department of air pollution control; Freeman Holmer, Wisconsin resource development administrator; and Gordon R. Engebretson, Ph.D., assistant director of the American Medical Association's department of environmental health.

Dr. Christopher R. Dix, president of the MSMC, welcomed the group of physicians and health workers. *Dr. Chesley P. Erwin*, chairman of the Public Relations Committee of MSMC, moderated the symposium.

A meeting on "Abortion—Is There A Need for Redefinition?" was sponsored by The Medical Society of Milwaukee County at Wingspread, The Johnson Foundation conference center at Racine, Sept. 27.

Representatives of hospital medical staffs in Milwaukee and Racine counties were invited to participate. *Dr. Frank E. Drew* of Milwaukee moderated the program.

Panelists who led discussions were *Dr. Eleanor Delfs*, professor of obstetrics, and Patrick J. and Margaret G. McMahon professor of gynecology and obstetrics, Marquette University School of Medicine, Milwaukee; E. Michael McCann, LL.M., assistant district attorney, Milwaukee County, Milwaukee; Ralph J. Podell, LL.B., chairman, State Bar of Wisconsin Family Law Section, Milwaukee; the Rev. Christopher G. Raible, B.D., minister, Unitarian Church West, Brookfield; and Dr. Ervin Teplin, associate clinical professor of psychiatry, Marquette University School of Medicine, and assistant clinical professor of psychiatry, University of Wisconsin Medical School, Milwaukee.

The conference is the first in a series of six monthly in-depth discussions of current problems of special interest to the medical profession called "Dialogues in Contemporary Medicine."

The dialogues are intended to provide a basis for further discussion of the subjects in the medical community.

Future programs will consider leisure time, changing medicine to fit the future, defining legal sanity, overpopulation, and government medicine.

WALWORTH

Dr. Gordon Marlow of Madison discussed "Common Problems in Disease of the Rectum and Colon" at the Sept. 21 meeting of the Walworth County Medical Society, at Elkhorn. Discussants included Drs. Marlow, *Kenneth Bill, Henry Mol, Richard Rogers, R. S. Galgano, Edward Hudson, William Woods, Joseph Schrock, Edward Sorenson*, and others.

During the business session a committee for mental health, retardation, and alcoholism was appointed as follows: *Drs. William Woods, Joseph Schrock*, and *Dean Jeffers*. In addition to the treasurer's report, a report was given by the coordinating committee to WPS.

Twenty-seven members, wives, and guests attended the meeting which was held at the Sterlingworth Motor Inn.

WINNEBAGO

Dr. G. C. Bernhard of Milwaukee discussed "Modern Concepts in the Diagnosis and Management of Gout" at the October 5 meeting of the Winnebago County Medical Society, Oshkosh.

Physicians whose names appear in italics are members of the State Medical Society.

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SPECIALTY SOCIETY PROCEEDINGS

Wisconsin Psychiatric Association

At the meeting of the Wisconsin Psychiatric Association on Sept. 9, the following recommendations were made for officers in the Section on Psychiatry and Neurology of the State Medical Society for the year 1967–1968 to replace *Dr. B. Cullen Burris* who has moved out of the state: president—*Dr. Leigh M. Roberts;* alternate delegate —Doctor Roberts.

Milwaukee Academy of Medicine

The Milwaukee Academy of Medicine met Oct. 17 at the University Club of Milwaukee for its 936th meeting. Dr. Paul A. Campbell, colonel, USAF (retired), presented the major topic, "Some of the Most Interesting Facets of Man in Space, the Moon, and Beyond."

Physicians whose names appear in italics are members of the State Medical Society.

Wisconsin Academy of General Practice

Among the notable speakers at the annual session was Dr. Francis Land of Washington, D. C., director of Title 19, the federal medicaid program. Another highlight was a panel on burns featuring *Dr. George E. Collentine, Jr.* of St. Mary's Hospital Burn Center in Milwaukee; Dr. Ronald Dietzman of the University of Minnesota Medical School; Dr. Stephen Lewis of the Galveston, Tex., Burn Center and the Shriner's Hospital for Burns; and *Dr. Joseph Darin* of Marquette University.

Other features included a session on obstetrics and gynecology with *Dr. C. Robert Jackson* of Madison, Dr. John Barton of Chicago, Dr. Emerson Day of the Strang Clinic in New York City, and Dr. Bruce F. P. Williams of the Duluth Clinic; a session on care of heart patients with the well known Dr. Edmund Foley of Chicago, and Dr. Herbert Bessinger of Chicago.

A theme on adolescents featured *Dr. Seymour Halleck*, psychiatrist from the University of Wisconsin; George Vukelich, radio personality from Madison, who spoke on "Hippies and Squares: Who Needs Help?", and the Hon. George Bowman, Jr., juvenile court judge in Milwaukee, who spoke on "The Ones Who Get Caught."

Dr. Richard Shropshire of Madison was program chairman.

MEDICAL STAFF

OWEN OTTO, M. D.
Medical Director
EUGENE B. FRANK, M. D.
LOREN J. DRISCOLL, M. D.
THOMAS J. GORAL, M. D.
JOHN J. O'HARA, M. D.
EARL F. WEIR, M. D.
LEROY WAUCK, Ph. D.
Clinical Psychologist
ROBERT TESTIN, Ph. D.
Clinical Psychologist

Phone 567–5535
MILWAUKEE OFFICE—BRoadway 3–6622

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Wisconsin Regional Medical Program

The advisory committee to the Wisconsin Regional Medical Program met in late September to explore the opportunities for cooperative activities with health agencies, the medical professions, university medical centers, and local hospitals.

About 25 committee members joined WRMP staff members for the day-long conference at Employers Insurance at Wausau. T. A. Duckworth, Employers senior vice-president and secretary, is advisory committee chairman.

Dr. John S. Hirschboeck, WRMP coordinator, indicated that the program had already received more than a half million dollars in little over a year from the National Institutes of Health for planning and programs.

Dr. L. J. Van Hecke of Milwaukee moderated a committee study group which considered possibilities of cooperative programs among the health agencies and professions. General agreement was reached that WRMP must initially gain acceptance and understanding of the medical professions.

The main objective nationally is to develop research programs and conduct educational activities to continue medical advances and spread information to the practicing physician and other medical professions as promptly as possible.

Dr. George Handy, acting state health officer, noted that a part of the regional medical program may be the education of the public to gain that acceptance of medical treatment even after it is available.

Voluntary cooperative activity possibilities among hospitals was another of the study group topics, with a number of possibilities offered.

Possible cooperative activities suggested included the collection and dissemination of information, educational activities, activities among hospital staffs, planning of area needs and disease diagnosis.

A third group considered the role of the medical center in cooperating with local hospitals and clinics. Here it was also generally agreed that the potential role is largely one of information and education.

Manitowoc County Medical Assistants

Members of the Kewaunee–Door County Medical Assistants Society were guests of the Manitowoc CMAS at its first meeting of the season in Holy Family Hospital, Manitowoc.

Dr. Michael Jacobi was speaker and guided the group on a tour of the hospital radiology section. He explained the cobalt unit and the isotope laboratory and also showed slides of cases, illustrating the hiatus hernia and duodenal ulcer.

Medical Conference Near Pembine

Over the space of 25 years in the midst of a northern Marinette County community, The Four Seasons Club of Pembine has been host to important medical meetings known as the Pembine Medical Conferences where the country's most learned medical men gather each year to study the treatment of lung cancer and chest disorders.

A highlight of the Pembine Conference was a presentation to Dr. John Towey, now retired and a resident of Middleton, who was honored by his colleagues for a long and distinguished career in service to medicine and the public. The Pembine Conference was started in 1942 by Doctor Towey, who for years was head of the State of Michigan's T.B. Sanitorium at Powers, Mich.

Attendance of the 75 participants, including department heads from Mayo Clinic, is by invitation only, the conference being sponsored by the Minnesota, Michigan, and Wisconsin Thoracic Societies.

Physicians whose names appear in italics are members of the State Medical Society.

PARAMEDICAL ANCILLARY GROUPS

Wisconsin Medical Assistants Certified

Four Wisconsin medical assistants were among a group of 74 who were honored at a luncheon Oct. 14 in Los Angeles in conjunction with the 11th annual convention of the American Association of Medical Assistants. The honor was in recognition of their certification in 1967. They are: Sandra Doyle, Wisconsin Rapids; Catherine T. Fuhrman, Milwaukee; Peggy S. Gallagher, Waukesha; and Jane M. Staszewski, Big Bend.

"Certified Medical Assistants," according to AAMA certifying board chairman, Mrs. Mary Kinn, Santa Anna, Calif., "have achieved the highest professional level, and thus are rated as the best qualified and most highly skilled medical assistants in the nation."

Marquette–Jackson Clinic Day

The thirty-seventh annual Marquette–Jackson Clinic Postgraduate Meeting was held Oct. 11 at the Park Motor Inn, Madison.

Dr. William B. Parsons, Jr. and *Dr. John H. Morledge* of the Jackson Clinic were chairmen of the program.

Participants were welcomed by *Dr. Luther E. Holmgren*, president of the Jackson Clinic staff. Jackson Clinic staff members who presented the first portion of the program were: Dr. Carl G. Silverman (Internal Medicine), *Dr. Gordon A. Tuffli* (Pediatrics), and *Dr. Paul A. McLeod* (Ob-Gyn).

The second part of the program included the following Marquette members: *Dr. Joseph C. Darin* (Surgery), Dr. Edward J. Lenon (Medicine), and *Dr. Sanford J. Larson* (Neurosurgery). A panel discussion on EXERCISE IN DIAGNOSIS AND TREATMENT OF CARDIOVASCULAR DISEASE was presented by JC members: Drs. Parsons, *D. William Hurst* (Inter-

nal Medicine), Morledge (Internal Medicine), and *Allen J. Pois* (Cardiovascular Surgery).

A social hour and dinner followed the scientific program. Observance of the 50th anniversary of the Jackson Clinic was a highlight of the dinner and guests enjoyed a skit entitled HOW NOW SACRED COW.

Wisconsin Chapter, Hemophilia Foundation

The Wisconsin Chapter of the National Hemophilia Foundation is searching for a little boy with hemophilia, between the ages of 5 and 10 years, who could become its poster boy for the Chapter's 1968 Fund Drive. Physicians are invited to help in the search. Applications may be obtained from the Wisconsin Chapter, 5214 North 63rd Street, Milwaukee, Wis. 53218, no later than Nov. 30, 1967.

* * *

A PAIN-STOPPING DEVICE has been developed by a La Crosse physician, Dr. C. Norman Shealy of the Gundersen Clinic. A quarter-sized device, implanted in the spinal cord, has effectively blocked pain in experimental animals and proved successful in one human patient. The device is connected by a platinum wire to a miniature radio receiver, implanted in muscle near the spinal area, which is controlled by an external transmitter. Doctor Shealy is working with support from the Adolf Gundersen Medical Foundation of La Crosse and a recent grant from the Boothroyd Foundation of Chicago. "More experimental time is needed," Doctor Shealy said, "before widespread use of the device will be considered."

* * *

MORE THAN 90 MADISON DOCTORS have agreed to treat children injured in the Vietnam war, it was announced in September. The Madison Committee of Responsibility said Vietnamese children who could not get treatment in their native land would be brought to this country for care. Angus B. Rothwell, executive director of the Coordinating Committee for Higher Education and Committee chairman, said the group was "neither hawks nor doves," but was interested in the humanitarian approach.

MEDICAL EDUCATION IN WISCONSIN

University of Wisconsin–Milwaukee Plans Medical School

The University of Wisconsin Board of Regents Sept. 15 endorsed a proposal for the establishment of a medical school at the UW–M. The decision came following a request of the Governor's Task Force on Medical Education to the UW for suggestions of ways to meet the pressing needs of medical education in the future of Wisconsin, after determining that the state's output of trained doctors must almost double and reach 360 by 1975.

The proposal for a UW–M medical school was for 1980, according to information received by the Task Force.

J. Martin Klotschke, UW–M chancellor, said it actually was a logical step after their decision four and a half years ago to make UW–M a major university.

The Task Force, at a meeting Oct. 23 in Madison, endorsed state spending to expand Wisconsin's two existing medical schools and to develop a third medical school in Milwaukee. Under this proposal, the state would help finance expansion of both the UW medical school at Madison and the Marquette medical school in Milwaukee to freshman enrollments of 160 each. It would help finance development of a UW–M medical school in Milwaukee with a freshman enrollment of 100.

Not resolved was the question of whether the state's financial support of Marquette, now a private school, would be approved by the legislature.

Marquette Medical School Separates from University

The Marquette University School of Medicine Sept. 30 broke its ties with the University after 51 years and was reorganized as the Marquette School of Medicine, Inc.

The reorganization was intended to remove any obstacles to participation of the school in a medical center for southeastern Wisconsin which the school and county general hospital would be the nucleus. Marquette County had previously suggested that the state subsidize the Marquette medical school by channeling funds through the county. This suggestion was met with opposition on constitutionality grounds. The new composition of the medical school apparently is aimed at solving the problems of state aid to a religious organization.

Named as the new president was Milwaukee attorney and civic leader, Louis Quarles. He succeeds Marquette University president, the Very Rev. John P. Raynor, who also had been president and chairman of the medical school board. Under the new organization, the governing board will consist of 15 directors. John W. Cowee, who had been on the University medical school board because of his position as vice-president of the University for business and finance, was elected to the new medical school governing board as a public member. He also was elected vice-president of the reorganized board. He had been its secretary. Dr. Gerald A. Kerrigan remains dean of the medical school.

The school plans to build a new medical school building near county general hospital and sell its present building to the University.

Diagnosis:

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pyelonephritis?
pyelitis?
urethritis?
prostatitis?

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usually gram-negative*

Therapy:

two 500 mg. Caplets® q.i.d.
(initial adult dose)

Indications: Urinary tract infections caused by gram-negative and some gram-positive organisms.

Side effects: Mainly mild, transient gastrointestinal disturbances; in occasional instances, drowsiness, fatigue, pruritus, rash, urticaria, mild eosinophilia, reversible subjective visual disturbances (overbrightness of lights, change in visual color perception, difficulty in focusing, decrease in visual acuity and double vision), and reversible photosensitivity reactions. Marked overdosage, coupled with certain predisposing factors, has produced brief convulsions in a few patients.

Precautions: As with all new drugs, blood and liver function tests are advisable during prolonged treatment. **Pending further experience, like most chemotherapeutic agents, this drug should not be given in the first trimester of pregnancy. It must be used cautiously in patients with liver disease or severe impairment of kidney function.** Because photosensitivity reactions have occurred in a small number of cases, patients should be cautioned to avoid unnecessary exposure to direct sunlight while receiving NegGram, and if a reaction occurs, therapy should be discontinued. The dosage recommended for adults and children should not arbitrarily be doubled unless under the careful supervision of a physician. Bacterial resistance may develop.

When testing the urine for glucose in patients receiving NegGram, Clinistix® Reagent Strips or Tes-Tape® should be used since other reagents give a false-positive reaction.

Dosage: Adults: Four Gm. daily by mouth (2 Caplets® of 500 mg. four times daily) for one to two weeks. Thereafter, if prolonged treatment is indicated, the dosage may be reduced to two Gm. daily. Children may be given approximately *25 mg. per pound* of body weight per day, administered in divided doses. The dosage recommended above for adults and children should not arbitrarily be doubled unless under the careful supervision of a physician. Until further experience is gained, infants under 1 month should not be treated with the drug.

How supplied: Buff-colored, scored Caplets® of **500 mg. for adults,** conveniently available in bottles of 56 (sufficient for one full week of therapy) and in bottles of 1000. **250 mg. for children,** available in bottles of 56 and 1000.

References: (1) Based on 23 clinical papers, 1512 cases. Bibliography on request. (2) Bush, I. M., Orkin, L. A., and Winter, J. W., in Sylvester, J. C.: Antimicrobial Agents and Chemotherapy—1964, Ann Arbor, American Society for Microbiology, 1965, p. 722.

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*As many as 9 out of 10 urinary tract infections are now caused by gram-negative organisms: E. coli, Klebsiella, Aerobacter, Proteus, Paracolon or Pseudomonas[2]... However, infections of the urethra and prostate caused by non-gonococcal gram-negative organisms are believed to be less prevalent.

OBITUARIES

Dr. Robert C. Thackery, 82, a retired Racine physician died Aug. 5, 1967, in Wausau.

Doctor Thackery graduated from Marquette University School of Medicine in 1912 and completed his internship at Trinity Hospital. He was a member of the Racine County Medical Society, State Medical Society of Wisconsin, and American Medical Association.

Survivors include a daughter, Mrs. Ruth Monk, Wausau.

Dr. Robert S. Baldwin, 62, a retired Marshfield physician, died unexpectedly Aug. 29, 1967, at the family's summer home on Beaver Lake near Hartland. Death came less than two days after the Baldwin family had gathered for the marriage of their daughter, Grace Roberta.

Doctor Baldwin was a widely known member of the Marshfield Clinic during a tenure which extended from 1934 to 1965. He had moved in 1965 to Florida where he took a position with the Florida State Board of Health, working with migrant workers and reservation Indians, a position which meant a lighter case load and duties which involved mostly preventive medicine and supervising public health measures.

While in Wisconsin, Doctor Baldwin was active in the Marshfield Clinic administrative affairs as well as his medical practice. He held numerous professional society memberships, including England's Royal Society of Medicine and the American College of Physicians. He was medical editor of the *Wisconsin Medical Journal* from 1950 through 1962 and consulting editor until 1965. He served on the State Medical Society of Wisconsin's Commission on Medical Care Plans and the Council on Scientific Work, later named the Commission on Scientific Medicine.

Doctor Baldwin was born Dec. 29, 1904, in Munising, Mich. He graduated from Rush Medical College, Chicago, in 1932, and took his internship at Cook County Hospital, Chicago. He took residencies in pathology, neurology, and neurosurgery at Cook County Hospital and Presbyterian Hospital in Chicago. He joined the Marshfield Clinic following his neurology residency and practiced in that field until a few years ago. His specialty was diabetes, but he also cared for psychiatric patients.

Doctor Baldwin enjoyed the outdoors and was active in veterans affairs. As an Army medical officer during World War II, he had the opportunity to observe the practice of medicine around the world.

Commissioned a captain and discharged as a lieutenant colonel, he began his five years of Army service as chief medical officer of the Milwaukee induction station. He was named chief of medicine at Ft. Sheridan, Ill., and then assigned similar duties with the 10th Evacuation Hospital in Australia and later in New Guinea.

In September 1944, he was assigned to a station hospital in England and later transferred to France, where he was chief of medicine for the 227th General Hospital. When World War II ended, Doctor Baldwin was medical consultant for 13 hospitals in and around Mourmelon.

Doctor Baldwin was a former member of the Wood County Medical Society and the State Medical Society of Wisconsin, and was a member of the Lee–Hendry County Medical Society, Florida Medical Association, and the American Medical Association.

He is survived by his widow, Dr. Elizabeth Reddeman Baldwin of Marshfield; two sons, Edwin, a Naval Academy graduate and a Lt. Commander in the nuclear reactor department of the USS Enterprise; Dr. Stanley, a resident of Boston Children's Hospital, Mass.; and two daughters, Mrs. Lorin (Martha) Loverde, Berkeley, Calif.; and Mrs. Chadwick (Grace) Letton, Mount Carroll, Ill.

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MARSHFIELD NEWS–HERALD, Aug. 31, 1967

Note of Mourning

Death no matter how we may choose to interpret its meaning, is by its very finality in human terms, a chastening experience for those who are left to mourn the one who has been summoned from their presence.

The Marshfield community has been triply bereaved during the past few days by the passing of three persons whose lives had closely touched those of many local residents over a long period of years.

The death of Dr. Robert S. Baldwin, only two days after the wedding of a daughter had brought his family together for a festive reunion, shocked the many who had known him both as a friend and physician. Marshfield's medical clinic had been established for less than a score of years when he joined its staff. Brilliant and many-sided, he was one of those who early recognized its vast potential and labored diligently to facilitate its growth. His talents, as well as those of colleagues, nourished the soil from which the promising Clinic Research Foundation has sprung. He contributed more to his fellows than most mortals can or do. . . .

Dr. Harold J. Belson, 63, Manitowoc, died Sept. 5, 1967 in Manitowoc.

Doctor Belson graduated from the Marquette University School of Medicine in 1932 and interned at St. Mary's Hospital in Milwaukee. He did residency work at the Hajak Clinic in Vienna, Austria. Doctor Belson was a past president of the Manitowoc County Medical Society, and a member of the State Medical Society of Wisconsin, and American Medical Association. He was a past president of the Michigan–Central Wisconsin Society of Ophthalmology and Otolaryngology.

Surviving are his widow and four children.

Dr. Walter M. Kearns, Sr., 72, retired Milwaukee physician, died Sept. 9, 1967, in Milwaukee.

Born in Milwaukee Doctor Kearns graduated from the Marquette University School of Medicine in 1920 and completed his internship at Marquette University Hospital. He served his residency at St. Luke's Hospital in New York City.

Doctor Kearns was on the medical staffs of Columbia, St. Mary's, St. Luke's, Milwaukee Lutheran, Mount Sinai, and Milwaukee County General hospitals. He was president of the County General Hospital medical staff in 1952.

Doctor Kearns was a member of The Medical Society of Milwaukee County, the State Medical Society of Wisconsin, and American Medical Association.

He was a certified diplomate of the American Board of Urology, an associate clinical professor emeritus of the Marquette University Department of Surgery, a fellow of the American and International College of Surgeons, and a member of the American Urological Association. Doctor Kearns was president of the Wisconsin Urological Society in 1932, president of the North Central Section of the American Urological Association in 1941, and vice-president of the Section of Urology of the American Medical Association in 1936.

Surviving are his widow, Barbara; two sons, Dr. Walter M. Kearns, Jr., and Dr. John W. Kearns; and a daughter, Mrs. Barbara Nesbitt.

Dr. Frederick W. Seegers, 88, Milwaukee, died Sept. 18, 1967, in Milwaukee.

Doctor Seegers graduated from the St. Louis University School of Medicine in 1906 and practiced in Wisconsin until 1948 when he retired.

He was a member of The Medical Society of Milwaukee County, State Medical Society of Wisconsin, and American Medical Association.

Surviving are his widow, Gladys; two daughters, Mrs. Verna Gerbic of Farmington, Conn., and Mrs. Dorothy Forster of Hanover, N. H., and a son, Frederick H. Seegers of Midland, Mich.

Dr. Norman C. Erdmann, 57, Manitowoc, died September 19, 1967.

Doctor Erdmann graduated from the Marquette University School of Medicine in 1933 and took his internship at St. Agnes Hospital in Fond du Lac. He served in the United States Army from 1943 to 1946.

Doctor Erdmann was a member of the Manitowoc County Medical Society, State Medical Society of Wisconsin, and American Medical Association. He also was a diplomate of the National Board of Medical Examiners and a member of the American Academy of General Practice.

Surviving are his widow and three children.

Dr. Henry C. Johnson, 76, Eugene, Ore., died Sept. 20, 1967, in Oregon.

Doctor Johnson graduated from Rush Medical College of Chicago in 1917. He was an overseas veteran of both World wars and served as the personal physician to the family of General Douglas MacArthur. Doctor Johnson practiced in Madison for 20 years before re-entering service in 1941.

He was a member of the Dane County Medical Society, State Medical Society of Wisconsin, and American Medical Association.

Surviving are his widow, Eva; three daughters, Mrs. Robert Salisbury of Madison, Mrs. Ed Trione, East Lansing, Mich., and Corvalis, Ore., and a son, Kenneth, Menomonee Falls.

Dr. Jack C. Wilets, 61, Milwaukee, died Oct. 5, 1967, in Milwaukee.

Doctor Wilets graduated from the Marquette University School of Medicine in 1932 and interned at Mt. Sinai Hospital in Milwaukee. He was a member of The Medical Society of Milwaukee County, State Medical Society of Wisconsin, and American Medical Association.

Surviving are a son, Daniel and a daughter, Nancy.

Dr. Gilbert R. Sandgren, 52, Suring, died Oct. 5, 1967, in Oconto.

Doctor Sandgren graduated from the Marquette University School of Medicine in Milwaukee in 1949 and interned at St. Joseph's Hospital at Marshfield. He had practiced in Suring since 1950, and received an award from the President of the United States for service to the Selective Service System in 1953 and 1967.

Doctor Sandgren was a member and past president of the Oconto County Medical Society, State Medical Society of Wisconsin, and American Medical Association. He also was a member of the American Academy of General Practice.

Surviving are his widow, Herta; and one son, Gilbert.

Dr. Clarence F. McDonald, 72, Milwaukee, died Oct. 7, 1967, in Milwaukee.

Doctor McDonald graduated from the Marquette University School of Medicine in 1924, interned at St. Mary's Hospital in Milwaukee, and practiced in Milwaukee since 1925. He served as president of the Wisconsin Academy of General Practice in 1954 and also as an alternate delegate to the State Medical Society of Wisconsin. Doctor McDonald was a member of The Medical Society of Milwaukee County, State Medical Society of Wisconsin, and American Medical Association.

Surviving are a son, John W., and a daughter, Patricia A. Gearhard, of Atlantic Beach, Fla.

Dr. Paul C. Wagner, 86, a retired Milwaukee physician died Oct. 11, 1967, in Milwaukee.

Doctor Wagner graduated from the Munich University School of Medicine, Germany, in 1906. He came to this country in 1924 and was licensed to practice in Wisconsin. He was a member of The Medical Society of Milwaukee County, State Medical Society of Wisconsin, and American Medical Association.

Surviving is his widow, Irma.

SOCIETY RECORDS

MEMBERSHIP REPORT AS OF SEPTEMBER 29, 1967

NEW MEMBERS

Esener, Ismail, Southern Wisconsin Colony, Union Grove 53182
Martinex, Enrique, 2405 Northwestern Ave., Racine 53404

CHANGES OF ADDRESS

Babbitz, Albert L., 1028 East Juneau Ave., Milwaukee 53202
Bailey, D. W., 2722 West Oklahoma Ave., Milwaukee 53215
Bauer, C. A., Milwaukee, to 1765 Wedgewood Drive West, Elm Grove 53122
Bessiere, Milton C., Route 2, Box 15-D, Alexander, Ark. 72002
Bryan, Albert R., La Grange, Ill., to 279th Station Hospital, Berlin, Germany, APO 09742, New York
Burris, B. C., Milwaukee, to 1247 Ridge Ave., Evanston, Ill. 60202
Carey, Larry C., Winchester, Mass., to 13005 Elmhurst Parkway, Elm Grove 53122
Cruz, Nazario R., 723—58th St., Kenosha 53140
Downes, Virginia, Milwaukee, to Box 204, 1200 West Cedar St., Cherokee, Iowa 51012
Eisenberg, Louis A., 1610 North Prospect Ave., Milwaukee 53202
Engstrom, Denton P., 610 East Longview Drive, Appleton 54911
Goldstein, David N., Box 743, Kenosha 53141
Hagerty, Warren T., 1040 South Van Buren, Green Bay 54301
Keane, Keith M., 610 East Longview Drive, Appleton 54911
Kohn, Albert, 909 North Fremont St., Stevens Point 54481
Knight, Curtis C., 2878 Kingston Drive, Madison 53713
Kroncke, George M., Portsmouth, Virginia, to 6006 Galley Court, Madison 53705
Larson, Craig, 811 East Wisconsin Ave., Milwaukee 53202
Lokietz, Howard, 1212 West Wisconsin Ave., Milwaukee 53233
Manhart, Richard A., Madison, to 885 Grandview Drive, Elm Grove 53122
May, James E., Washington, D. C., to U. S. Naval Hospital, Bremerton, Wash. 98314
McCarey, Arthur J., 1114 Emilie, Green Bay 54301
McCredie, Samuel R., 1700 West Wisconsin Ave., Milwaukee 53233
Moore, George E., 525 East Wells St., Milwaukee 53202
Nimz, Robert A., 4921 West Wisconsin Ave., Milwaukee 53208
Otterson, W. N., Fort Lewis, Wash., to USA MC Ryuby Islands, APO 96331, San Francisco, Calif. 94100
Plautz, Arthur C., San Francisco, Calif., to 05541024, U. S. Army General Hospital, Fort Campbell, Ky. 42223
Randall, John H., Green Bay, to Fitzsimons Hospital, Denver, Colo.
Rau, Esther L., Box 1059, Janesville 53545
Reyes, Jose E., Kenosha, to 319 Hormon Ave., Danville, Ill. 61832
Rosenthal, Stoyan P., Milwaukee, to 200 South Middle Neck Road, Great Neck, New York 10020
Silagi, Miklos J., 2814 North Holton Ave., Milwaukee 53214
Smith, Charles C., 541 West Briar Lane, Green Bay 54301
Stebbins, Walter W., Madison, to 222 Eighth Ave., North, St. Petersburg, Fla. 33701
Tang, Thomas T., 1700 West Wisconsin Ave., Milwaukee 53233
Tibbetts, Palmer G., 2330 Swan Blvd., Milwaukee 53202
Tomkens, Samuel W., 925 East Wells Street, Milwaukee 53202
Waun, James E., Madison, to 1006 North Sherman, Ludington, Mich. 49431
Weissler, Joseph B., 610 East Longview Drive, Appleton 54911
Weston, Carl B., 1659 Sherman Ave., Madison 53704
Weston, Frank L., 1659 Sherman Ave., Madison 53704
Wilkinson, Dudley E., Silver Bay, Minn., to 200 East Forest Street, Mora, Minn. 55051
Zaun, John J., Jr., Phoenix, Ariz., to 702 North 74th St., Scottsdale, Ariz. 85257

DEATHS

Schmit, Louis, Milwaukee County, July 30, 1967
Baldwin, Robert S., nonmember, Aug. 29, 1967
Belson, Harold J., Manitowoc County, Sept. 5, 1967
Kearns, Walter M., Milwaukee County, Sept. 9, 1967
Seegers, Frederick W., Milwaukee County, Sept. 18, 1967
Erdmann, Norman C., Manitowoc County, Sept. 19, 1967
Johnson, H. Curtis, Dane County, Sept. 20, 1967
Conway, Hugh P., nonmember, Sept. 22, 1967

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BOOKSHELF

New books received are acknowledged in this section. From these books, selections will be made for reviews in the interest of the readers and as space permits, Reviews are written by members of the faculty of the University of Wisconsin Medical School. Books here listed will be available on loan from the Medical Library Service, S.M.I. Building, North Charter Street, Madison, Wisconsin 53706

NEW DRUGS

1967 edition evaluated by A.M.A. Council on Drugs, American Medical Association, 535 N. Dearborn St., Chicago, Ill. 60610, 1967, pp 590. Price: $3.50. (Special price to medical students, residents, and interns: $1.75.)

The physician must have readily available sources of balanced, authoritative information in order to cope effectively with the complexities of modern pharmacotherapy. *New Drugs*, a publication of the A.M.A. Council on Drugs, now in its third edition, provides such information on new drugs.

The 1967 edition of *New Drugs* is a compilation of introductory statements on various therapeutic classes of drugs and monographs on single-entity drugs marketed in the United States during the period 1957–1966. It contains 265 individual drug monographs, each of which gives information on the actions and uses of the drug and its adverse reactions, contraindications or precautions, dosages and routes of administration, and sizes and strengths of available preparations. The introductory statements to 21 chapters have been thoroughly revised and 10 new monographs have been added, These monographs and introductory statements are based on a thorough review and evaluation by the Council on Drugs and its consultants of all of the laboratory and clinical information, including unpublished data, available to them. Thus, the book presents a concise, unbiased assessment of the newer drugs within the perspective of the therapeutic application of all of the commonly used agents in a particular class of drugs. Since a monograph on a drug is included whether or not the Council's opinion is favorable, *New Drugs* is in no sense a list of approved or accepted drugs.

The index lists drugs by both their nonproprietary (generic) and trade names and includes therapeutic entries. A list of Canadian trade names equivalents is given in the appendix.—AMERICAN MEDICAL ASSOCIATION

THERAPEUTIC RADIOLOGY

Rationale, technique, results. By William T. Moss, M.D., Professor of Radiology, Department of Radiology, Northwestern University School of Medicine, Chicago; Director of Therapeutic Radiology, Chicago Wesley Memorial Hospital; Chief, Department of Therapeutic Radiology, Veterans Administration Research Hospital, Chicago. Second edition. C. V. Mosby Co., St. Louis. 1965. 514 pages. Price: $18.75.

Dr. L. V. Ackerman writes in his foreword: "This unique and practical book on radiation therapy critically appraises and well illustrates the indications for and the limitations of conventional and supervoltage therapy. The effects of irradiation on normal tissues are detailed preliminary to discussing the therapy for cancers of individual organs, which in itself makes this work important and of utmost value. Dr. Moss, with a background in clinical medicine, a balanced training in radiotherapy in the United States, England and France, and wide personal experience in the treatment of cancer, brings to radiotherapy a crystallized practical viewpoint. The surgeon, otolaryngologist and gynecologist in particular will find here a dispassionate discussion of the merits and contraindications of radiation therapy of different organs. The author has described the ideal results as well as the complications to be expected under certain circumstances. While this book will be widely used by the radiologist, it should be of great value to the young physician beginning a career in radiotherapy. To the pathologist, this book will be invaluable as a source of knowledge on the effects of irradiation on normal tissues."

Doctor Ackerman's foreword describes this book well. It has become the standard textbook in the teaching program in radiotherapy at the University of Wisconsin Medical School and in many other medical schools and can be recommended without reservation to every physician dealing with cancer. The book has 170 illustrations and contains innumerable references to important publications.—HALVOR VERMUND, M.D., PH.D.

THE SMALL INTESTINE—ITS FUNCTION AND DISEASES

By Thomas W. Sheehy, M.D., F.A.C.P., and Martin H. Floch, M.S., M.D., Hoeber Medical Division, Harper and Row, Publishers, New York 16, N. Y. 1964. 479 pages. Price: $20.00.

Doctors Sheeby and Floch have brought emphasis to a much neglected area of medicine and have produced a book that deserves a place in the library of every physician who deals with gastrointestinal disease. It is comprehensive in scope and after a concise introduction to anatomy, physiology and diagnostic testing of the small intestine reviews in organized fashion most of the disease problems which have major impact on this organ. The review of malabsorptive problems and sprue is exhaustive and would be difficult to improve in a reasonable space. Discussion of other processes varies considerably in extent, with some being exhaustive but others so brief as to be more tantalizing than definitive. Fortunately an excellent bibliography is appended to most sections and the references chosen are largely in easily available English language journals so that the reader who has access to a moderately well stocked library should be able to pursue those matters which interest him without too

much difficulty. The overall format of the book makes it easily read and the numerous roentgenographic reproductions and photomicrographs are of unusually excellent quality and clearly make their point even to the unsophisticated reader.—J. L. SIMS, M.D.

REHABILITATION MEDICINE

By Howard A. Rusk, M.D., C. V. Mosby Co., St. Louis, Mo. 1964. 668 pages. Price: $15.50.

The second edition of this book outlines current basic treatment techniques in the various aspects of rehabilitation medicine then discusses their application to numerous clinical entities. It is written especially for those physicians who wish a reference book on rehabilitation procedures and will be of interest also to those undertaking post-graduate training in physical medicine and rehabilitation.

The book is divided into two sections. Part I deals with the principles of rehabilitation medicine, the philosophy, evaluation process, therapeutic exercise, occupational therapy, activities of daily living, rehabilitation nursing, braces, crutches, wheel chairs, orthodontics home making and housing management of psychiatric problems, communication impairment, social problems, vocational problems and principles of prescription writing. Part II deals with the application of the principles of rehabilitation medicine to selected medical problems, such as metabolic diseases, cerebral palsy, poliomyelitis, cancer and others. A chapter is devoted to rehabilitation problems of children and another to geriatric rehabilitation.

Several chapters have been revised extensively to include current thinking on the sensory, perceptual and other neurological deficits of cerebral palsy patients and their problems of vocational rehabilitation. The section on cardiac rehabilitation and pulmonary problems have been expanded. The chapter on hemiplegia has been rewritten.

The book contains excellent pictures, charts and graphs and is organized so that information on any particular subject can be obtained rapidly.—MARGARET A. KOHLI, ED.M.

REVIEW BOOK RECEIVED

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TEXTBOOK OF PULMONARY DISEASES

Edited by Gerald L. Baum, M.D. 737 pp, 43 illus. $27.50. Little, Brown and Company, 34 Beacon Street, Boston, Mass., 1965.

Rarely does any textbook fill the diverse needs of the inquiring student, the busy generalist and sophisticated specialist. This volume does. Each subject is treated analytically by a recognized authority. The latest discoveries in the biologic sciences are skillfully integrated with traditional knowledge so as to present new insight into many puzzling clinical problems as well as to provide the proper scientific basis for modern clinical practices. The inclusion of numerous previously unpublished original observations and useful practical hints attest to the authors' everyday familiarity with their respective subjects. Although at first this *Textbook of Pulmonary Diseases* appears to have been written by specialists for specialists, closer inspection will reveal a wealth of clinical information, including the latest methods of treatment of immediate value to the generalist, as well as an orderly presentation of broad principles and physical diagnosis suitable to the beginning student. The latest sophisticated laboratory tests are placed in proper perspective with the traditional tools of the physician to the benefit of both. Several conventional topics such as tuberculosis are given a refreshingly new look while others, such as acute bronchial inflammation, are brilliantly condensed. The relation of structure to function is emphasized throughout. The gross, microscopic and submicroscopic anatomy of the lung are presented with a wealth of superbly reproduced half tone illustrations including 43 in color. Extensive background information is produced in the chapters dealing with obstructive and interstitial diseases of the lung which provide the reader with a sound physiologic basis for clinical interpretation and rational therapy. Similarly, the various chapters dealing with allergic disease of the lung provide more than an adequate background evidence to lend support to a widely held view that future advances in lung disease will parallel advances in immunology. Other highlights include chapters on developmental anatomy, the pulmonary circulation, the extra pulmonary neoplasms, and an informative approach to the handling of pneumonia.

A unique feature is the inclusion of laminated lung macrosections from a normal subject and patient with emphysema which can be viewed with a simple hand lens or microscope. Bibliographical references are conveniently grouped at the end of each chapter.

The present volume is not just another addition to old treatises or merely a review of recent advances but an authoritative analysis of the rapidly growing field of pulmonary disease which performs a real service for the clinical investigator and specialist, a stimulant to the curious student and a wealth of practical answers to perplexing clinical problems for the practitioner. The editors, author and publisher are to be congratulated.—JOHN RANKIN, M.D.

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MEDICAL MEETINGS

POSTGRADUATE COURSES

1968 WISCONSIN

Jan. 15–26: Advanced Maternity Program in Delivery Room Nursing for graduate nurses, Marquette University College of Nursing, Milwaukee.

Jan. 18: UW "In-Depth" postgraduate teaching program, Madison.

Chicago

Feb. 7–8: "Modern Separation Methods of Macromolecules and Particles," University of Wisconsin, Madison.

Feb. 12–23: Advanced Maternity Program in Delivery Room Nursing for graduate nurses, Marquette University College of Nursing, Milwaukee.

Feb. 13–15: Annual meeting, Wisconsin Academy of General Practice, Mt. Telemark, Cable.

Feb. 21: UW "In-Depth" postgraduate teaching program, Madison.

Mar. 4: Postgraduate course, "Hypoglycemias in Infants and Children," sponsored by Marquette University at Children's Hospital, Milwaukee.

Mar. 11: Postgraduate course, "Etiology and Management of Nephrosis in Children," sponsored by Marquette University at Children's Hospital, Milwaukee.

Mar. 11–22: Advanced Maternity Program in Delivery Room Nursing for graduate nurses, Marquette University College of Nursing, Milwaukee.

Mar. 18: Postgraduate course, "Prevention of Mental Retardation," sponsored by Marquette University at Children's Hospital, Milwaukee.

Mar. 21: UW "In-Depth" postgraduate teaching program, Madison.

Mar. 23: Town and Gown Symposium, State Medical Society of Wisconsin, Madison.

Mar. 25: Postgraduate course, "Emotional Crises Among Adolescents," sponsored by Marquette University, Milwaukee.

Mar. 27–28: Sports Medicine and General Medicine, University of Wisconsin, Madison.

Apr. 4–5: Wisconsin Anti-Tuberculosis annual meeting, Milwaukee.

Apr. 4–6: Fetus and Newborn, University of Wisconsin, Madison.

Apr. 18–19: Conference for Directors of Nursing in Small Hospitals, University Extension, Marshfield.

Apr. 22–May 3: Advanced Maternity Program in Delivery Room Nursing for graduate nurses, Marquette University College of Nursing, Milwaukee.

May 9–10: Conference for Directors of Nursing in Small Hospitals, University Extension, Madison.

May 14–16: Annual meeting, State Medical Society of Wisconsin, Milwaukee.

June 8: Semi-annual meeting, Wisconsin Society of Pathologists, University Hospitals, Madison.

1968 NEIGHBORING STATES

Jan. 19–20: Course in "New Concepts in Problems of Completed Stroke," Kenny Rehabilitation Institute, Minneapolis, Minn.

Mar. 7–8: Institute of Medicine of Chicago Workshop —The Doctor and His Hospital, Pick-Congress Hotel,

1968 OTHERS

Jan. 10–12: "Current Concepts in Cardiology," Institute for Cardiovascular Diseases at Good Samaritan Hospital, Phoenix, Ariz.

Jan. 11–13: Surgery seminar, Univ. of Miami School of Medicine, Eden Roc Hotel, Miami Beach, Fla.

Jan. 14–18: Second annual meeting of the Society of Cryo-Ophthalmology, Miami Beach, Fla.

Jan. 15–19: Program — Neurology and the Internist, American College of Physicians with Univ. of Miami School of Medicine, Eden Roc Hotel, Miami Beach, Fla.

Feb. 19–21: First of three 1968 sectional meetings in Dallas, Tex., of the American College of Surgeons.

Mar. 4–7: New Orleans Graduate Medical Assembly, Roosevelt Hotel, New Orleans, La.

Apr. 21–27: Interamerican Congress of Cardiology, Lima, Peru.

Apr. 22–25: American Industrial Health Conference, Hilton Hotel, San Francisco, Calif.

May 4–9: Annual teaching seminar, International Academy of Proctology, Montreux–Palace Hotel, Montreux, Switzerland.

May 13–17: Annual meeting, Ohio State Medical Association, Cincinnati, the Netherland Hilton Hotel.

Sept. 18–20: Sixth National Cancer Conference, Denver Hilton Hotel, Colo.

Sept. 28–Oct. 3: Western Hemisphere Congress, International College of Surgeons, Honolulu, Hawaii.

Oct. 6–11: XVI Biennial International Congress, International College of Surgeons, Tokyo, Japan.

Oct. 16–26: Scientific and Clinical Seminars in Hong Kong, Manila, and Bangkok, International College of Surgeons.

Oct. 21–25: Annual Clinical Congress, American College of Surgeons, Atlantic City, N.J.

Oct. 26–Nov. 11: Around-the-World Postgraduate Clinics, International College of Surgeons, India, Egypt, Holy Land, Israel, and Greece.

1969 OTHERS

Apr. 21–24: American Industrial Health Conference, Shamrock Hilton Hotel, Houston, Tex.

1968 AMA

Jan. 11–13: First International Conference on Prematurity, Pier 66, Ft. Lauderdale, Fla.

Jan. 18–20: "The Community and Emergency Medical Services" conference, San Francisco Hilton Hotel, Calif.

Mar. 29–30: National Conference on Rural Health, Olympic Hotel, Seattle, Wash.

For listing of other meetings see the JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION.

Interamerican Congress of Cardiology

The American Heart Association's Department of Council and International Program, is coordinating the final arrangement for United States participation in the VIII Interamerican Congress of Cardiology, Lima, Peru, April 21–27, 1968.

The congress will include a two-day scientific session, a trade exhibit and a four-day meeting of the delegates to the Interamerican Society of Cardiology. Two symposiums or roundtable meetings will be held simultaneously each day.

The following subjects have been selected for discussion at the congress meetings: Present Status of the Heart Valve Replacements, Experiences in Intensive Coronary Care Units, Present Status of Auscultation and Fonocardiography, Surgery of Coronary Artery Disease, Experimental and Clinical

Progress in the Development of Artificial Heart, Cardiac Arrhythmics, Progress in Diagnosis and Treatment of Congenital Heart Disease, Metabolic Bases of Cardiovascular Therapy, Pharmacology and Clinical Use of Beta Adrenergic Blocking Agents, Rheumatic Fever, Cardiomyopathies, and The Heart and the Circulation at High Altitudes.

Those who wish to attend the six-day conference must have their enrollment cards to the Congress Secretariat in Lima, by Jan. 1, 1968. It is suggested that hotel reservations also be made by this time. Enrollment cards and hotel accommodation cards may be obtained through the Wisconsin Heart Association, 205 W. Highland Ave., Milwaukee, Wis. 53203.

The New Orleans Graduate Medical Assembly

The thirty-first annual meeting of The New Orleans Graduate Medical Assembly will be held March 4–7, 1968, headquarters at The Roosevelt Hotel.

Nineteen outstanding guest speakers will participate and their presentations will be of interest to both specialists and general practitioners. The program will include 51 informative discussions on many topics of current medical interest, in addition to a clinicopathologic conference, symposia, medical motion pictures, roundtable luncheons, and technical exhibits. This program is acceptable for 32 elective hours by the American Academy of General Practice.

An interesting and enjoyable program of entertainment for visiting ladies has been planned.

Of special interest will be a one-day, pre-Assembly symposium scheduled for Sunday, March 3, on "Sexual Problems in Clinical Practice." Six papers, together with a panel discussion, will be presented by six authorities on this subject.

Current Concepts in Cardiology

An intensive program on "Current Concepts in Cardiology" is being offered by the Institute for Cardiovascular Diseases at Good Samaritan Hospital, Phoenix, Ariz., and the American College of Cardiology. This meeting will be held at Del Webb's Towne House, Phoenix, Jan. 10, 11 and 12, 1968.

Program director, Alberto Benchimol, M.D. with guest faculty, E. Grey Dimond, M.D., William Chardack, M.D., Darrell D. Fanestil, M.D., Mr. Dean Franklin, George C. Griffith, M.D., Paul G. Hugenholtz, M.D., Albert A. Kattus, Jr., M.D., C. Walton Lillehei, M.D., Oscar Magidson, M.D., Alfred Pick, M.D., Robert L. Van Citters, M.D.

This is an official program of the American College of Cardiology. For information about this program write to William D. Nelligan, Executive Director, American College of Cardiology, 9650 Rockville Pike, Bethesda, Md., 20014.

UW "In-depth" Teaching Programs

Three University of Wisconsin programs in a series of four "in-depth" teaching sessions will be held early in 1968. The fourth, "Marriage on the Rocks," was held December 6.

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MEDICAL MEETINGS *continued*

The one-day sessions are held in the morning at the University Hospitals, Room 300, and at noon and afternoon at the State Medical Society headquarters in Madison.

"Clinical Immunology and Allergy" will be held January 18. Faculty includes: Drs. Charles E. Reed, William L. Kopp, Mark Mueller, E. Richard Stiehm, and Derek J. Cripps. Topics are: Common diseases demanding immunological and allergic management —Rheumatoid arthritis, asthma, drug eruptions, cutaneous manifestations of collagen diseases.

On February 21, the subject will be "Hypertension." Faculty members are: Drs. Harriet P. Dustan (Cleveland), Charles W. Crumpton, William C. Boake, Richard E. Rieselbach, Theodore Goodfriend, and Neville Bittar. Topics are: Diagnosis of hyper-

WISCONSIN STATE MEDICAL ASSISTANTS SOCIETY

NINTH EDUCATIONAL SYMPOSIUM
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Saturday, Feb. 3, 1968

8:00 **REGISTRATION:** Coffee and Danish Rolls (courtesy of Medico-Mart, Inc., Milwaukee)

9:00 **WELCOME:** Miss Donna Schultz, Menasha, President, Wisconsin State Medical Assistants Society; and Harold J. Kief, M.D., Fond du Lac, President, The State Medical Society of Wisconsin

9:30 **"WHERE IS THAT RECORD?":** Miss Barbara J. Ryan, R.R.L., Director, Medical Records Department, Mount Sinai Hospital, Milwaukee
"HOW YOU FILE DOES MAKE A DIFFERENCE": Mr. Robert H. Baldwin, Diebold, Inc., Milwaukee

10:30 **"DO I SOUND LIKE THAT?":** Joseph M. Staudacher, Professor of Speech, Marquette University, Milwaukee

12:15 **LUNCHEON**

1:30 **"THE EXPERTS' ANSWERS":** Panel of doctors—Nicholas F. Damiano, M.D., General Practice, Milwaukee; and Donald J. Chrzan, M.D., Otolaryngology, Milwaukee

2:30 **"WORK SMARTER AND NOT HARDER":** Clinical Aspects—Mrs. Margaret Biggs, Central Service Supervisor, Milwaukee County Hospital, Milwaukee (all props, courtesy of Medico-Mart, Inc.); and Administrative Aspects—Mr. Robert F. Koehne, Gaarder & Miller, Inc., Milwaukee

3:30 **SUMMARY**

tension—Validity of clinical tests in hypertension—renal hypertension—Physiological effects of drugs in hypertension.

The March 21 program will deal with "Anticoagulants." Faculty members are: Drs. Park W. Willis (Ann Arbor), Ovid O. Meyer, Donald R. Korst, Dallas V. Clatanoff, John H. Morledge, Alfred L. Kennan, and Kenneth M. Klatt.

Topics are: Patient presentations—Basic mechanisms and laboratory control—Use in cerebrovascular disease and chronic cardiac disease—Complications and their management—Clinical uses in surgical, obstetric and orthopedic problems.

The programs are approved for four hours of credit by the American Academy of General Practice. Registration fees: $5.00 per meeting.

Co sponsors of the programs with the University are the Madison Chapter of the Wisconsin Academy of General Practice, Merck Sharp & Dohme Postgraduate Program, and the CES Foundation of the State Medical Society.

Town and Gown Symposium

The Commission on Hospital Relations and Medical Education of the State Medical Society is making plans for presentation of a second Town and Gown Symposium to be held at the State Medical Society headquarters in Madison on March 23.

Current plans call for two or three major presentations during the morning, a noon luncheon, and an afternoon session of workshops, with this session concluding with a general discussion of the results of the workshops.

To date, Dr. James L. Dennis has accepted an invitation to speak. He is vice-president and dean of the University of Oklahoma Medical Center, Oklahoma City. His subject will be "Does Medical Education Have a Role in the Delivery of Health Services?".

Telemark Meeting of GPs

The annual meeting of the Wisconsin Academy of General Practice will be held Feb. 13–15, 1968, at Cable. Scientific sessions, featuring a faculty from the Mayo Clinic, will be held each day at the Mt. Telemark Ski Lodge. The purpose of the meeting is to provide a combination scientific program with a ski outing. This is the fourth year of the Telemark symposium. It is sponsored by the Indianhead Chapter of the WAGP. Pre-registration is not necessary. Those wishing to attend must make their own room reservations at one of the motels or lodges in the area. Write directly to the manager, Mt. Telemark Ski Area, Cable, Wis.

* * *

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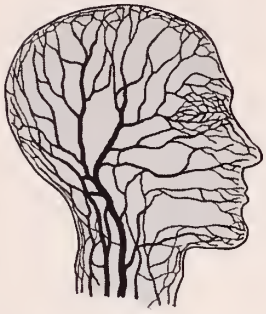

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Every practicing physician recognizes the unquestionable need for timely aid to the kin of his profession who face unusual financial hardship. Personal hardship strikes at physicians and their families as well as others. Through the Foundation there is an opportunity for professional persons to assist their colleagues who suffer adversity.

The Scientific medicine activities of the Foundation include circuit teaching programs, speakers service for county medical societies, and the support of research in many fields in cooperation with other agencies.

The Foundation has not neglected the value of learning from the past and the Museum of Medical Progress and Stovall Hall of Health, reconstruction of the Fort Crawford Hospital in Prairie du Chien, have made many visitors aware of the role that medicine has and is playing in their lives.

The voluntary contributions recommended by the House of Delegates is being supplemented by many physicians and others who find in the Foundation an opportunity for special gifts. Gifts may take a number of forms such as cash, life insurance, securities, books, old medical instruments, stamp and coin collections, works of art and other artifacts. Some physicians are making the Foundation a beneficiary in their wills. Gifts may be unrestricted, permitting the Trustees to use the funds for any purpose for which the Foundation was created. They may also be restricted or earmarked for specific purposes of interest to the donor. In any event, all contributions to the Foundation are deductible for income tax purposes.

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Historic Gas Light Modernized for Society "Home"

Erection of an historic lamp on the front lawn of the State Medical Society "home" was completed recently and its donor, Donald E. Gill, is nostalgically pleased.

The lamp, originally lighted by gas, was one of those used at the old state capitol, 1857–1904, when it was destroyed by fire. It now lights electrically; its glow can be seen for some distance across the lake. It is ideally situated at the top of the steps leading to the Society pier in Lake Monona.

The lamp was donated in 1960 by Mr. Gill in tribute to his physician forebears: Dr. Galen Rood, Stevens Point, 1830–1917; Dr. Charles A. Gill, Madison, 1855–1935; Dr. Joseph F. Gill, Madison, 1858–1918; Dr. James C. Gill, Chicago, 1863–1935; Dr. Quincy O. Sutherland, Janesville, 1848–1909; Dr. Charles Sutherland, Janesville, 1876–1929; Dr. Fred Sutherland, Minnesota, 1884–1960—granduncle, uncles, and cousins—all of a line distinguished in their pioneer service to the public weal.

The donor, Donald E. Gill, is a certified public accountant and a partner in the firm of Donald E. Gill & Co. of Madison. His interests, aside from the professional aspects, are varied. He also is a gentleman farmer who operates a dairy farm that has been in the family for 113 years. He is particularly interested in the historical activities of the Society's CES Foundation to which he donated the lamp as well as other items of significance.

DR. JAMES C. FOX, chairman of the Council, presented the first annual Gundersen Recognition Award to Dr. Joseph C. Darin of Wauwatosa at a dinner meeting of councilors and officers November 4.

Dr. Joseph Darin Receives First Annual Gunnar Gundersen Award

A Wauwatosa physician, Dr. Joseph C. Darin, received the first annual Gunnar Gundersen Recognition Award from the State Medical Society for his "continued contributions to science" and his surgical teaching exhibit at the Society's annual meeting in Milwaukee last May. The presentation was made November 4 following a dinner attended by councilors and officers of the Society and invited guests.

Doctor Darin is assistant professor of surgery at Marquette School of Medicine in Milwaukee. His winning exhibit described studies, conducted at Marquette under his direction, of methods to overcome liver failure by circulating the patient's blood outside his body, through other human livers. The studies indicate this method as promising a means of regenerating normal liver function.

Doctor Darin is a 1954 graduate of Marquette University School of Medicine. He interned at Columbia Hospital, then took his surgical residency at Veterans Administration Hospital, Wood. He

entered military service in 1960, where he served as chief of the trauma study branch of the U. S. Army Surgical Research Unit.

The Gundersen Award, established in 1966 during the State Medical Society's 125th anniversary, is named after the La Crosse physician who heads the clinic bearing his name. Doctor Gundersen is a former president of the State Medical Society and the American Medical Association.

Gunnar Gundersen Medallion

Dr. Gunnar Gundersen

MEETINGS AND SPECIAL EVENTS HELD AT THE STATE MEDICAL SOCIETY "HOME" DURING THE MONTH OF NOVEMBER 1967

1 Advisory Committee to State Alcoholism Services
1 "Care of the Premature Infant", SMS Division on Maternal and Child Welfare, Wisconsin Division of Health, and UW Medical School (Neenah)
2 "Care of the Premature Infant", SMS Division on Maternal and Child Welfare, Wisconsin Division of Health, and UW Medical School (Tomahawk)
4 Council, SMS (Gunnar Gundersen, MD, medallion presentation)
4 Executive Committee of Council, SMS
6 Madison Academy of Internal Medicine
6 Insurance Advisory Committee, Dane County Medical Society
7 Board of Trustees, Dane County Medical Society
7 SMS Division on Chest Diseases
7 Madison Anesthesiology Society
7 Surgical Staff, Madison General Hospital
7 Cardiology Study Committee, Wisconsin Regional Medical Program
7 Madison Urology Society
8 Health Council (Madison)
9 SMS Division on Alcoholism and Addiction
10 Cancer Study Committee, Wisconsin Regional Medical Program
11 Executive Committee, SMS Commission on Medical Care Plans
11 SMS Commission on Medical Care Plans
11 Educational Committee, Wisconsin Regional Medical Program
11 Cancer Study Committee, Wisconsin Regional Medical Program
13 Conference on Quackery, SMS (Milwaukee)
13 SMS Commission on Public Policy (Milwaukee)
14 Conference on Quackery, SMS (Milwaukee)
16 Conference on Ophthalmology, SMS
16 Cardiology Study Committee, Wisconsin Regional Medical Program
18 University of Wisconsin Medical School Preceptors
20 Stroke Study Committee, Wisconsin Regional Medical Program
26 AMA Clinical Convention (Houston, Tex.)
27 AMA Clinical Convention (Houston, Tex.)
28 AMA Clinical Convention (Houston, Tex.)
29 AMA Clinical Convention (Houston, Tex.)

Meetings not held in the Society "Home" but which have a direct relationship are printed in italics, with the location in parentheses.

5,000 Yearly Fatalities for Motorcyclists

An orthopedic surgeon has predicted 5,000 annual fatalities for motorcyclists by 1970, and said that 80%–90% of accidents involving motorcycles cause injury to the occupants.

Dr. Richard C. Dillihunt, Portland, Maine, told an audience at Wisconsin Work Week of Health, Oct. 16–20 in Madison, that death rates for motorcycle riders are more than double those injured in auto accidents. Doctor Dillihunt spoke on the first day of the five-day public meeting sponsored by the State Medical Society. The day's topic was traffic safety and rescue of accident victims.

More than 2,000 persons were killed in motorcycle accidents in 1966, Doctor Dillihunt said.

He said that often the motorcyclist is not responsible for the accident which injures him, but that "in many cases it appears that the driver is young and inexperienced and learns only too late that his vehicle is not just a big bicycle," the surgeon said.

SUPPORT YOUR FOUNDATION

It is your opportunity to give financial assistance to the charitable, educational and scientific aspects of medicine as they relate to the health and well-being of the people of Wisconsin. Gifts may take a number of forms such as cash, life insurance, securities, land, books, instruments, stamp and coin collections, works of art and other artifacts. Some physicians are making the Foundation a beneficiary of their wills. In any event, all contributions to the Foundation are deductible for income tax purposes. Checks may be made out to: CES Foundation, and sent to CES Foundation, State Medical Society of Wisconsin, Box 1109, Madison, Wisconsin 53701.

Dr. Shropshire Missionary Speaker

Dr. Richard W. Shropshire of Madison was a featured speaker at the annual meeting of the United Church Board for World Ministries at St. Lucas United Church of Christ in St. Louis, Mo., November 14–17.

Doctor Shropshire inspected missionary programs of the United Church in India for the Board this year. Since his return in February he has been speaking to church groups throughout Wisconsin about the kinds of work missionaries perform today. Doctor Shropshire has for the past few years given the fee for delivering one baby per month to the work of missionary doctors in India.

Dr. Arthur Hansen Retires

One of Wisconsins' early specialists in industrial medicine retired October 31 after 36 years association with A. O. Smith Corporation. He is *Dr. Arthur C. Hansen*, who will be succeeded as corporate medical director by *Dr. H. James Hamm*. The medical director supervises A. O. Smith's medical program which includes employe examinations, first aid treatment, and medical care in workmen's compensation cases.

A. C. Hansen, M.D.

H. J. Hamm, M.D.

A native of Racine and a 1929 medical school graduate of the University of Wisconsin at Madison, Doctor Hansen joined A. O. Smith in 1942 after serving in a consulting capacity as assistant surgeon from 1931. He interned and was a resident doctor at Milwaukee Hospital (now Lutheran Hospital of Milwaukee). He continued with his private practice until 1952.

Doctor Hansen is a member of the American Medical Association, the state and county medical societies, the American Academy of Occupational Medicine, the Industrial Medical Association, and the Royal Society of Health in London, England.

Doctor Hamm, a Marquette University Medical School graduate, joined A. O. Smith as associate medical director in October 1966. Doctor Hamm interned at Milwaukee Hospital and was a resident doctor there and at University Hospitals in Madison. He had been in private practice from 1962, and is certified by the American Board of Internal Medicine.

Doctor Hamm is a member of the American Medical Association, the state and county medical societies, the Milwaukee Academy of Medicine, the American Heart Association, and the Industrial Medical Association.

Physicians whose names appear in italics are members of the State Medical Society.

NEWS OF WISCONSIN PHYSICIANS

Joins Dean Clinic

Dr. Donald A. Daugherty, Madison, recently joined the Dean Clinic in the practice of Internal Medicine. He is a graduate of the Marquette University School of Medicine and completed his internship at the Philadelphia General Hospital.

Dr. Yao Opens Office

Dr. Filemon Yao recently opened his office in Whitewater. He graduated from the University of Santo Tomas in The Philippines, took his internship at McNiel Hospital, Berwyn, Ill., and spent four years in residency at Little Company of Mary Hospital in Evergreen Park, Ill. Doctor Yao was a surgeon and a house physician at St. Anthony Hospital, Chicago, before coming to Whitewater.

Dr. Madden Receives Award

Dr. William J. Madden, Racine, recently was the recipient of St. Norbert College's alma mater award. The award was given for "vocational success and outstanding service in Christian life."

Dr. McSweeny Attends Meeting

Dr. Austin J. McSweeny, Janesville, recently returned from Los Angeles where he attended the Western Divisional Meeting of the American Psychiatric Association.

Dr. Heise Elected to AAGP

Dr. Lawrence F. Heise, Tigerton, recently was elected to active membership in the American Academy of General Practice.

Dr. Elizabeth Baldwin Leaves Marshfield

Dr. Elizabeth Baldwin, Marshfield's health officer, recently resigned her position and moved to Port Charlotte, Fla. Doctor Baldwin has been appointed to the staff of the Medical Center in Punta Gorda, Fla.

She served as city health officer since her appointment in 1953 and served as a member of the State Board of Health from 1957 to 1964. Doctor Baldwin was also a member of the St. Joseph's Hospital staff in Marshfield.

Doctors Join Staff at Lawrence University

Three Appleton doctors have been added to the consulting staff of the Lawrence University Health Center. They are *Drs. Jack Anderson, Keith Keane,* and *Gilbert Mueller, Jr.*

Dr. Hacker Leaves for Navy Service

Dr. Philip Hacker, Stevens Point, recently was called into active duty by the Navy and will serve a two-year tour of duty.

Dr. Weygandt Guest Speaker

Dr. James L. Weygandt, Sheboygan Falls, recently spoke on the prevention of "dead drivers" before the Suburban Federation of Republican Women at Brown Deer. Doctor Weygandt is a member of the National Safety Council and chairman of the State Medical Society's Commission on Safe Transportation.

Dr. Burns Guest Speaker

Dr. Robert Burns, Madison, recently spoke before the University of Wisconsin Medical School's Chapter of Med-Wives.

Dr. Eckstam Guest on Panel

Dr. Eugene Eckstam, Monroe, recently was a guest on a panel which discussed "What Will The World Be Like in the 1980s" before the Fall Council meeting of Badger Council of Girl Scouts. Doctor Eckstam discussed the advances in medicine and science and how they affected our lives.

Dr. McCutcheon Guest Speaker

Dr. M. L. McCutcheon, Neenah, recently was the guest speaker before the Neenah–Menasha Jaycettes at a meeting held in Neenah. Doctor McCutcheon's topic was "The Toddler Age Child."

Dr. Vogel Heads Kiwanis Club

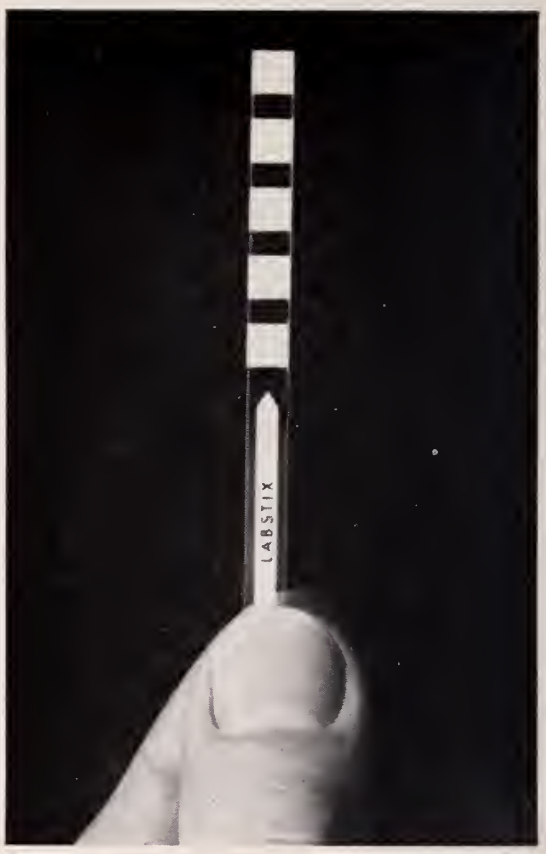
Dr. Thorn Vogel, Janesville, recently was elected president of the Kiwanis Club. Doctor Vogel is the city health commissioner of Janesville.

Dr. Bostian Guest Speaker

Dr. K. E. Bostian, Janesville, recently spoke on accidental poisoning in small children at a dinner meeting of the Catholic Junior League in Janesville.

Dr. Gottlieb Featured in Newspaper

Dr. A. M. Gottlieb, Madison, recently was featured in the WISCONSIN STATE JOURNAL. Doctor Gottlieb is the director of the Veterans Administration Hospital and is also clinical professor of internal medicine at the University of Wisconsin. Doctor Gottlieb entered the VA service in 1937 and served in VA hospitals in Hines, Ill.; Tuscaloosa, Ala.; Wood, Wis.; and Dearborn, Mich., before coming to Madison in 1959. He also was the chief cardiologist with the 71st Evacuation Hospital in New Guinea, Dutch East Indies, and The Philippines. He has written many articles for medical journals and is listed in the Directory of Medical Specialists, "American Men of Science," "Who's Who in World Jewry," and "Who's Who in the Midwest."



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Dr. End Named Medical Director

Dr. Jack A. End, Milwaukee, recently was named medical director of the Northwestern Mutual Life Insurance Company. He succeeds *Dr. Gamber F. Tegtmeyer*, Milwaukee, who retired after serving the company for 31 years.

Doctor End graduated from the Marquette University School of Medicine in 1941. He joined the U.S. public health service, was assigned to the U.S. Coast Guard, and worked at Marine hospitals. Doctor End took part in seven South Pacific invasions during two years of World War II, and joined NML in 1946 and became associate medical director in 1966.

Dr. Aquino Opens Office

Dr. E. C. Aquino, Monticello, recently opened an office in Monticello after a 20-month effort by local citizens. He is a graduate of the University of Santo Tomas and served his residency at Deaconess Hospital, Milwaukee and Omaha, Neb. His visa expired and he returned to The Philippines where he waited while local citizens, with the help of Senator Proxmire, contacted Washington officials. His waiver was approved and he returned to this country with his wife, a former Monticello resident, and his son.

Drs. Avestruz to Practice in Spring Valley

Dr. Alex Ponferrade Avestruz and his wife, Dr. Nerissa Lucuna Avestruz of The Philippines have been granted licenses under a special legislation, to practice in this country. The couple opened offices recently in the Spring Valley community which has been without a physician for sometime.

Science Building Named After Physician

The new science building at St. Norbert College, Green Bay, named after the late Dr. John R. Minahan, recently was dedicated. Taking part in the ceremonies was Dr. Kenneth Endicott, director of the National Cancer Institute, who received an honorary degree from the college. Doctor Endicott referred to Doctor Minahan as a physician of national and international reputation.

Dr. Jackson Heads Symposium

Dr. E. Basil Jackson, Bayside, recently was chairman of a symposium that was presented by the Milwaukee Psychiatric Hospital and the Department of Psychiatry, Marquette University School of Medicine. Doctor Jackson also presented a paper on "Correlates of Conscience."

Dr. Charles Raymond Headlee, Wauwatosa, president of the hospital's medical staff and acting chairman of Marquette's University Department of Psychiatry, was one of the discussants.

Dr. Benforado Guest Speaker

Dr. Joseph M. Benforado, Madison, was the guest speaker at the fall Youth Series recently held at the Covenant Presbyterian Church in Madison. He spoke on "LSD and Related Drugs."

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PHYSICIAN NEWS *continued*

Dr. Beno Serves in Vietnam

Dr. Thomas Beno, Green Bay, recently returned from Vietnam where he participated in Volunteer Physicians for Vietnam, a project started by the American Medical Association in 1966.

Dr. Crawford Guest Speaker

Dr. William A. Crawford, Oshkosh, recently was the guest speaker at the Oshkosh School for the Deaf and Hard of Hearing at Webster Stanley.

Dr. Treffert Guest Speaker

Dr. D. A. Treffert, Winnebago, recently was the guest speaker at a PTA meeting held at the Gillett High School. His topic discussed was "Adolescence, a Healthy Disease."

Dr. Siebens Addresses VNA

Dr. Arthur A. Siebens, Madison, chairman of the Department of Rehabilitation Medicine and director of the Rehabilitation Center, University of Wisconsin, recently spoke before the Visiting Nurse Association of Beloit. He spoke on "Innovations in Managing Severe Physical Disability."

Milwaukee Doctor in Vietnam

Lt. Cmdr. John A. Chopyak, Milwaukee, is serving in the Navy Hospital in Da Nang, South Vietnam. Doctor Chopyak entered the service last February and has been in Vietnam about three months on a 13-month tour.

Wisconsin Physicians on Panel

Several Wisconsin physicians recently were on a panel discussion held before the freshman medical students at the University of Wisconsin, Madison. They were: *Drs. Kenneth L. Strebe,* Oconto Falls; *Ben Lawton,* Marshfield Clinic; L. E. Hokin, T. L. Goodfriend, and *William Kiekhofer* from University Hospitals.

Dr. Klutzow Renamed Chief of Staff

Dr. Friedrich Klutzow, Gillett, recently was reappointed as Chief of Staff at the annual medical staff meeting of Community Memorial Hospital in Oconto Falls. *Dr. Kenneth L. Strebe* was reelected secretary and treasurer of the medical staff.

Dr. Wochos Relates Experiences About "Hope"

Dr. Robert Wochos, Green Bay, recently related his experiences about the hospital ship, SS HOPE, in South America, before the Kewaunee Woman's Club. Doctor Wochos served aboard the Hope earlier this year when it was moored at Carthagena, Colombia.

Dr. Ryan Featured in Newspaper

Dr. A. J. Ryan, Madison, Wisconsin team physician for the University of Wisconsin, recently related some of his experiences in the treatment of

injuries to athletes, which appeared in the WISCONSIN STATE JOURNAL. Doctor Ryan, formerly of Meridan, Conn., came to Madison a few years ago to join the University of Wisconsin faculty. He has set up a course at the University in sports medicine, the first of its kind, which runs eight months of the year instead of the usual two-day sports medicine seminar. Doctor Ryan, author of the book "Medical Care of Athletes," became interested in the treatment of injuries to athletes when, as a private surgeon, he treated athletes brought to him. He wrote a hard hitting editorial for the JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION a number of years ago, and as a result was made a member and later chairman of a newly organized Sports Injuries Committee of the AMA.

Dr. Garner Attends Meeting

Dr. Lawrence L. Garner, Wood, Assistant Chief, Outpatient Service, Veterans Administration Center, recently participated at the International Meeting on Primary Glaucoma held in Florence, Italy, at the National Congress of the Italian Ophthalmological Society. The paper presented was titled, "Tonography in the Diagnosis of Open-Angle Glaucoma." Doctor Garner recently established a tonography laboratory at the Center's outpatient area for the investigation of glaucoma.

Madison Doctors at Mental Health Meet

Drs. David Cline and Joseph Dzubay of Madison participated in an annual dinner meeting of the Grant County Mental Health Association October 19 at Dickeyville. Doctor Cline is a fellow in child psychiatry at the University of Wisconsin Medical School and spends two days per month at the Grant County Mental Health Clinic as a consultant to physicians, educators, clergy, courts, and welfare departments. Doctor Dzubay is associated with the University Hospitals and spends one day per week at the Lafayette and Iowa county Mental Health Branch Clinics.

Dr. Wochos Speaks to Practical Nurses

Dr. Robert Wochos of Green Bay showed slides and discussed his recent tour of service on the hospital ship SS HOPE, to the Wisconsin Licensed Practical Nurses Association annual convention in October at Green Bay. Other physicians who participated in the program were *Drs. Joseph Grace* and *F. J. Dega* of Green Bay.

Marshfield Doctors in Seminar

Dr. Russell L. Lewis, president of the Marshfield Clinic, welcomed 125 persons who attended a statewide seminar on the theme: "The Doctor's Assistant Tomorrow." The seminar was sponsored by the Marshfield Clinic Foundation for Medical Research and Education for visiting clinical-surgical technicians and aides. It was held November 4 in the auditorium of St. Joseph's Hospital School of Nursing. *Dr. Gerald E. Porter* of the Marshfield Clinic

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moderated a panel discussion on "The Physician's Assistant." *Dr. G. Stanley Custer*, also of the Marshfield Clinic, moderated a panel discussion. *Dr. Francis N. Lohrenz*, president of the Clinic Foundation, was program chairman.

Named to Cancer Group

Three physicians have been named to head committees of the Racine County Unit of the American Cancer Society by the unit president, *Dr. Leo Grinney* of Racine. Added to the board are *Drs. E. A. Stika, William F. Henken*, and *James B. Shack*, all of Racine.

Dr. Peckham Presents Paper

Dr. Ben M. Peckham, professor of gynecology and obstetrics, University of Wisconsin Medical Center, Madison, presented a paper at the annual meeting of the Southwestern Obstetrics–Gynecology Society Nov. 8–10 in Phoenix, Ariz.

Dr. Schultz to Vietnam

Dr. Isadore H. Schultz, Mazomanie general practitioner, left December 1 for a two months tour of service in Vietnam under the AMA "Volunteer Physicians for Vietnam" program.

Dr. Haupert Guest Speaker

Dr. A. Peter Haupert, Milwaukee, recently was the guest speaker at the annual Mission Festival Observance Sunday at the Moravian Church in Wisconsin Rapids. He is a graduate of the University of Pennsylvania Medical School. After completing his residency work in surgery, he plans on serving with the Moravian mission hospitals in Nicaragua.

Dr. Sullivan Addresses Pathologists

Dr. John F. Sullivan, associate pathologist at St. Elizabeth Hospital, Appleton, addressed a joint meeting of the Wisconsin Association of Medical Technologists and the Wisconsin Society of Pathologists at the Holiday Inn Center in Milwaukee November 10.

Attend Symposium in Detroit

Drs. Ben M. Peckham, Gloria E. Sarto, J. Morton Schneider and *Madeline Thornton*, Department of Gynecology and Obstetrics, University of Wisconsin Medical Center, Madison, attended a symposium on "Prenatal Life, Biological and Clinical Perspectives" Nov. 1–2 at Wayne State University, Detroit, Mich.

Dr. Schaefer Reports on Smoking

Dr. F. LeRoy Schaefer of Neenah spoke at a public meeting October 25 sponsored by the Outagamie County Unit of the American Cancer Society in which it was disclosed that experimental groups, similar to Alcoholics Anonymous, have been successful in helping the cigarette smoker to quit his habit.

Kenosha Physician to Vietnam

Dr. Leif H. Lokvam of Kenosha became the ninth volunteer physician from Wisconsin to serve two months in Vietnam administering care to the civilian population. His tour of service, which will end Dec. 21, was arranged through the AMA's program —Volunteer Physicians for Vietnam.

Doctor Lokvam graduated from the University of Wisconsin and received his medical degree from the University of Wisconsin Medical School. He is a past president of the State Medical Society. Doctor Lokvam currently is a general surgeon in private practice with affiliations at Kenosha Memorial and St. Catherine's hospitals, Kenosha.

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The Placement Service of the State Medical Society has helped many physicians find a new assistant, found promising locations for young practitioners, and brought resident medical service to many communities without a doctor.

Here is how the Placement Service may be able to help you. The Society maintains a continuous listing of names and biographical data on physicians who wish to locate in Wisconsin. Usually there are 30 to 50 generalists listed and a total of 80 to 125 specialists in all categories. The Society also maintains a list of physicians and communities offering opportunities to the physician in individual, group, and other types of practice. THE WISCONSIN MEDICAL JOURNAL offers a Physicians Exchange service each month at reasonable rates. Widows of deceased physicians who were members of the Society may use this service without charge.

Physicians who have used the Placement Service have described it as one of the most effective in the United States. JOURNAL advertising, too, has proved highly successful.

One word of advice: Advise the Society of your needs as soon as possible. Overnight results have occurred, but more time usually means better results.

COUNTY SOCIETY PROCEEDINGS

BROWN

At the October 12 meeting of the Brown County Medical Society, the following items were discussed at the business session:

The Society emphasized its desire to be represented on the Board of the Brown County Guidance Clinic. The situation arose following the death of Dr. Mason LeTellier who was a member of the Board.

The Brown County Bar Association had requested a meeting with the Legal Committee of the Society and *Dr. John Goelz* was named chairman of such a committee.

Members were requested to present nominations to *Dr. Lyle Edelblute* for the Medical Award for 1967.

A report on the United Fund campaign was given by *Dr. John Ottum.*

Dr. Jack Killins reported on his activities regarding ambulance service in Green Bay.

The Society endorsed a proposal of Dr. Cornelius Hopper, M.D., of the University of Wisconsin to establish a Multiple Sclerosis Clinic in Green Bay. The proposal was presented by *Dr. Daniel Shea,* chairman of the Curative Workshop and the Cerebral Palsy Committee.

Following the business meeting, *Dr. Robert Wochos* described his tour of duty on the hospital ship, SS HOPE.

CHIPPEWA

The November 7 meeting of the Chippewa County Medical Society was held at the Hotel Northern in Chippewa Falls. Earl R. Thayer, executive secretary of the Professional Association for Civic Education (PACE), addressed the group.

DODGE

The Dodge County Medical Society at its October 26 meeting gave its endorsement to the establishment of a marriage counseling service for the Dodge County Family Court. Judge Joseph E. Schultz, who presides in the Family Court, addressed the Society and explained his views on the need for such a service for the citizens of Dodge County.

MILWAUKEE

The medical and psychological effects of leisure time and how it is spent were discussed at a meeting sponsored by The Medical Society of Milwaukee County at Wingspread, The Johnson Foundation conference center at Racine, October 25. Representatives of hospital medical staffs in Milwaukee and Racine counties participated. This is the second in a series of six monthly in-depth discussions of current problems of special interest to the medical profession.

The meeting was moderated by *Dr. Roman E. Galasinski,* past president and director of the Society, who stated that pre-retirement counseling is a much better approach for a company than to "throw a party for a retiree, give him a watch and then precipitate him over a cliff into retirement and oblivion."

The efforts of one industrial firm in pre-retirement counseling were described by Walter F. Eckers, manager of plant personnel of the Jos. Schlitz Brewing Co., Milwaukee. Mr. Eckers said that a retired employes group was organized at Schlitz in 1961 and now has 417 active members. He said the company now has a counseling program for all employes who are approaching retirement age, discussing with them finances, whether they should own or rent a dwelling, whether it would be good to move to a different climate and what leisure activities they can undertake.

Paul J. Mundie, Ph.D., partner in a Milwaukee consulting firm, said companies, families, and retirees themselves should do more to help people adjust to retirement.

Dr. Chris J. Buscaglia, assistant professor of psychiatry, Marquette School of Medicine, and medical director of the North Division of the Milwaukee County Mental Health Center; and *Dr. Carl Zenz,* assistant clinical professor of Occupational Health and Environmental Medicine, Marquette School of Medicine, and director of Medical and Hygiene Services at Allis–Chalmers Manufacturing Co., West Allis, also participated on the panel.

OCONTO

At the October 17 meeting of the Oconto County Medical Society, *Dr. F. E. Zantow* of Oconto was elected president for the coming year. *Dr. K. L. Strebe* of Oconto Falls was elected vice-president and *Dr. John Honish* of Oconto was elected secretary-treasurer. *Dr. Robert D. Heinen* of Oconto was named delegate to the State Medical Society and Doctor Strebe was named alternate delegate. *Dr. Friedrich Klutzow* of Gillett was nominated as the program chairman for 1967–1968. Following a short business session the group was shown a movie relating to estrogen therapy.

WALWORTH

Twenty six members and wives of the Walworth County Medical Society met in Delavan October 28. Dr. John Kaysel of Rockford Memorial Hospital, Rockford, Ill., addressed the group on "Establishing an Intensive Coronary Care Unit." Discussants were

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Physicians whose names appear in italics are members of the State Medical Society.

Doctors Kenneth C. Bill, E. D. Sorenson, and *Henry R. Mol,* Elkhorn; *Harold J. Werbel, Glenn A. Smiley,* and *William C. Woods,* Delavan; *Joseph B. Schrock, Jr.,* Sharon; and *Daniel R. Hansen* and *Orhan G. Bingol,* Walworth.

A proposal for a mass immunization program for measles in Whitewater was referred to Whitewater physicians.

WAUKESHA

The Sept. 6 meeting of the Waukesha County Medical Society included a discussion of the salient points concerning the need and advantages of a combination public relations–executive secretary position for the Society. The discussion was led by an invited guest, Gale Brennan.

WOOD

Dr. H. K. Stinson of Marshfield presented a lecture, with films, on hip osteoarthritis at the September 28 meeting of the Wood County Medical Society. Thirty-four members were present.

* * *

AT MIDYEAR 1967, the Veterans Administration had guaranteed or insured 6,690,744 home loans which totaled more than $66 billion, and had disbursed 274,127 direct loans amounting to $2.5 billion in rural areas where ordinary lending facilities were not available to veterans.

* * *

AVERAGE HOSPITAL cost per patient day could rise close to $70.00 by 1970, according to Walter J. McNerney, President of the Blue Cross Association.

Division of Mental Hygiene Expands Services in Behalf of Children

Children's services offered by the Division of Mental Hygiene are being expanded through a new children's services section in the Division offices and a Children's Consultation Service which is in operation in the child-adolescent units of Mendota and Winnebago State Hospitals.

Dr. Robert O'Connor, formerly superintendent of the Diagnostic Center, heads the new children's services section which will work for the development and coordination of all services for mentally ill and retarded children in the state. He is also to coordinate the Children's Consultation Service (CCS) in the two hospitals.

The children's services section is further staffed by Dr. Henry Weiss, psychologist, and Warren Turner, social worker, both formerly of the Diagnostic Center.

In the new Children's Consultation Service a team of child specialists is available at each state hospital to provide consultation to child care and mental health agencies on problems related to mentally disturbed children. Each team has a psychiatrist, psychologist, social worker, nurse and teacher.

Agencies served include the Department of Health and Social Services, child welfare departments and agencies, the Department of Public Instruction (Bureau for Handicapped Children), community mental health clinics, residential treatment centers and juvenile courts. It also provides inpatient observation to children referred from the psychiatric and pediatric departments of the University Hospital, Madison.

The CCS usually provides consultation around an individual case referred by an agency. Occasionally problems are resolved by telephone. In such cases consultation may include helping agencies find appropriate inpatient treatment facilities or schools. Or it may be "backup" consultation to an agency which understands the child's problem but requests advice as to treatment. At times the CCS role is mediation—when the Service is asked to resolve some difficulty between agency and/or inter-agency personnel over a particular case.

When a child is referred to CCS an outpatient screening interview takes place at the hospital. The team social worker arranges the interview after an agency makes its referral request on forms supplied by the Service. All children entering the child–adolescent unit as voluntary patients are also screened by the CCS.

After the initial evaluation the staff recommends one of three courses of action for the child: (1) admittance to the child–adolescent unit for intensive treatment, (2) treatment on an outpatient basis with community-centered action or (3) further study and evaluation of the child as a CCS inpatient in the hospital for a period of from a few days to six weeks.

The Consultation Service had been planned as a function of the Wisconsin Diagnostic Center. When the Center closed due to reappropriation of funds in the 1967–69 budget, the CCS was put into operation in the two state hospitals.—WISCONSIN MENTAL HYGIENE REVIEW, October 1967

Wisconsin Academy of General Practice

Dr. G. J. Derus of Madison was elected president-elect of the Wisconsin Academy of General Practice at the association's annual meeting in Milwaukee September 28. Doctor Derus will succeed *Dr. Norbert G. Bauch* of Milwaukee as president in 1968. Doctor Bauch was installed as president at the annual meeting and will serve for one year.

Dr. Donald J. Heyrman of Menomonee Falls was reelected secretary–treasurer. *Dr. John G. Jamieson* of Racine was elected speaker of the Congress of Delegates and *Dr. Paul E. Wainscott* of Menasha was reelected vice-speaker.

Dr. George V. Murphy of South Milwaukee was elected chairman of the board of directors. Other directors are *Drs. Michael S. Garrity*, Prairie du Chien; *Joseph S. Kovacic*, Sheboygan; *Richard Shropshire*, Madison; *Charles M. Balliet*, Wausau; *Jack D. Brown*, Sparta; *Eugene M. Kay*, Milwaukee; *Leonard B. Torkelson*, Baldwin; and *A. J. Sanfelippo*, Milwaukee.

Dr. Charles J. Picard, Superior, and *Dr. Joseph S. Devitt*, Milwaukee, are delegates to the American Academy of General Practice. *Dr. Wendell D. Hamlin*, Mineral Point, and *Dr. Howard M. Klopf*, Menomonee Falls, are alternate delegates.

Physicians whose names appear in italics are members of the State Medical Society.

SPECIALTY SOCIETY PROCEEDINGS

Wisconsin Pediatrics Society

Dr. Frank Stiles of Monroe was named chairman of the Wisconsin Chapter of the American Academy of Pediatrics at a late October meeting of the group. He succeeds *Dr. Stewart Griggs* of Green Bay. *Dr. Charles Geppert* of Madison succeeds *Dr. Edward Zupanc* of Monroe as secretary-treasurer. Both terms are for three years. *Dr. William Bartlett* of Madison is the alternate chairman.

Doctor Stiles is chairman of the Department of Pediatrics at The Monroe Clinic, on the faculty of the medical schools of the University of Wisconsin and Marquette and he is medical director of The Monroe Rehabilitation Center, a local center for brain-injured children.

* * *

HOSPITAL COSTS during the first year of the Medicare Program increased by 13 per cent, according to Robert M. Ball, Social Security Commissioner.

WHAT IS AN OTOLARYNGOLOGIST? NEW FOLDER ANSWERS

When a physician speaks to a nonmedical person about an otolaryngologist, the response more likely than not is, "An oto—what?". In an effort to close this communications gap somewhat, and produce a better public understanding of the ear, nose and throat specialist, a new folder has been developed by the American Academy of Facial Plastic and Reconstructive Surgery. It's called "What Is An Otolaryngologist?".

The new folder defines and describes the scope of modern otolaryngology in simple terms, bringing into focus all aspects of the specialty. Physicians will be particularly interested in the newer activities of many practitioners in this field—tumor surgery, microsurgery of the ear, and plastic reconstructive surgery.

The brochure is available for distribution by physicians in their reception rooms at cost—$2.50 per 100. They can be obtained by writing to: Jack R. Anderson, M.D., 1111 Tulane Ave., New Orleans, La. 70112.

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Announcing THE THIRTY-FIRST ANNUAL MEETING OF

THE NEW ORLEANS GRADUATE MEDICAL ASSEMBLY

Conference Headquarters—Roosevelt Hotel—March 4, 5, 6, 7, 1968

GUEST SPEAKERS

Morris J. Nicholson, M. D., Boston, Mass.
ANESTHESIOLOGY
J. P. Nesselrod, M. D., Santa Barbara, Calif.
COLON AND RECTAL SURGERY
Robert W. Goltz, M. D., Denver, Colo
DERMATOLOGY
Charles H. Brown, M. D., Cleveland, Ohio
GASTROENTEROLOGY
George E. Burket Jr., M. D., Kingman, Kan.
GENERAL PRACTICE
J. George Moore, M. D., New York, N. Y.
GYNECOLOGY
William Dameshek, M. D., New York, N. Y.
INTERNAL MEDICINE
Oglesby Paul, M. D., Chicago, Ill.
INTERNAL MEDICINE
John A. Aita, M. D., Omaha, Neb.
NEUROLOGY
Robert B. Wilson, M. D., Rochester, Minn.
OBSTETRICS
Mack L. Clayton, M. D., Denver, Colo.
ORTHOPEDIC SURGERY
William H. Saunders, M. D., Columbus, Ohio
OTORHINOLARYNGOLOGY
Jon V. Straumfjord, Jr., M. D., Birmingham, Ala.
PATHOLOGY
Sydney S. Gellis, M. D., Boston, Mass.
PEDIATRICS
E. H. Schultz, Jr., M. D., Chapel Hill, N. C.
RADIOLOGY
Richard T. Shackelford, M. D., Baltimore, Md.
SURGERY
Kenneth W. Warren, M. D., Boston, Mass.
SURGERY
Laurence F. Greene, M. D., Rochester, Minn.
UROLOGY

Additional speaker to be announced.

Lectures, symposia, clinicopathologic conference, round-table luncheons, medical motion pictures, technical exhibits, and entertainment for visiting wives.

(All-inclusive registration fee—$30.00)

This program is acceptable for thirty-two (32) elective hours by the American Academy of General Practice.

For information concerning the Assembly meeting write Secretary, The New Orleans Graduate Medical Assembly, Room 1538, 1430 Tulane Avenue, New Orleans, Louisiana 70112.

Pre-Assembly Special Symposium—Sunday, March 3—"Sexual Problems in Clinical Practice."

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Hospital Employee Health Programs

A Conference on Hospital Employee Health Programs was presented November 30 at the Veterans Administration Center, Wood. Several physicians participated.

Dr. James Wilkie of Madison led a discussion on "Basic Elements of a Sound Employee Health Program: Who, What, Where, When, Why, and How." Doctor Wilkie is chairman of the Occupational Health Committee of the State Medical Society. He also participated in a discussion on "Overcoming Barriers in the Improvement of Employee Health Services."

Dr. Ursula Kutter participated in a discussion on "Establishing and Implementing an Employee Health Program." Doctor Kutter is medical director of the Employee Health Service, St. Mary's Hospital, Milwaukee.

A discussion of the "Role of the Physician and Nurse in Employee Health Programs" was led by *Dr. O. T. Mallery* of Wausau. *Dr. Joseph Devitt* of Milwaukee was a member of the discussion group. Doctor Mallery is medical director of Employers Insurance of Wausau and a member of the Occupational Health Committee of the State Medical Society. Doctor Devitt is chairman of the Commission on Health Information of the State Medical Society.

Sponsoring and cooperating organizations were the Wisconsin Hospital Association, Hospital Council of Greater Milwaukee Area, Occupational Health Committee of the State Medical Society of Wisconsin and The Medical Society of Milwaukee County, Occupational Health Nurses Section of the Wisconsin Nurses Association, and the Division of Health of the State Department of Health and Social Services.

Milwaukee County Medical Assistants

The Milwaukee County Medical Assistants Society held its monthly meeting November 16 at the Blue Cross–Blue Shield building in Milwaukee. Guest speaker was Mrs. Audrey Zirbel of Patricia Stevens Career College and Finishing School. She discussed "Charm in a Capsule."

An Education Symposium was held again this year by Milwaukee County on November 11 at the Holiday Inn–Midtown. Medical law, calories and weight, medical terminology, and psychiatry were discussed by speakers. There also was a question and answer period on Title 19, Title 18, and Medicare Extended.

A Christmas party was scheduled for December 13 at the Ramada Inn.

Allen–Bradley Science Laboratory

A $600,000 addition to the Allen–Bradley Medical Science Laboratory in Milwaukee was dedicated November 28. Three eminent surgeons and researchers were present for the program: Michael E. De Bakey, M.D. professor and chairman of the Department of Surgery at Baylor University College of Medicine in Houston, Tex.; James D. Hardy, M.D. professor and chairman of the Department of Surgery, University of Mississippi Medical Center; and Robert M. Zollinger, M.D. regent professor and chairman of the Department of Surgery at the Ohio State University College of Medicine.

The 18,000 square foot addition more than doubles the size of the Allen–Bradley Medical Science Laboratory, which has been in operation at the Milwaukee County Institutions since 1961.

General chairman of the dedication program was Dr. Edwin H. Ellison, professor and chairman of the Division of Surgery at the Marquette School of Medicine and originator of the research lab project.

Physicians whose names appear in italics are members of the State Medical Society.

PARAMEDICAL ANCILLARY GROUPS

Wisconsin Hospital Association

Edward J. Logan, administrator of Milwaukee Children's Hospital, was installed as president of the Wisconsin Hospital Association at its annual meeting in late October in Milwaukee. Gordon N. Johnsen, administrator of Madison General Hospital, was named president-elect. Other hospital administrators elected were: Leon Felson, Mount Sinai, Milwaukee, first vice-president; Sister Mary Joan, St. Agnes, Fond du Lac, second vice-president, and Fred H. Eggers, Calumet Memorial, Chilton, treasurer.

Father Edmund J. Goebel, director of Catholic hospitals for the Milwaukee archdiocese, was named to receive the hospital association's annual award of merit.

Hospital Honors Philipino Doctors

The Consul General of The Philippines was the featured speaker when Milwaukee's Deaconess Hospital saluted its Filipino physicians Tuesday, November 14.

Dr. Generoso P. Provido, representing The Philippines Republic, spoke at the hospital's special "Filipino Doctors' Recognition Day" dinner held at the Holiday Inn of America–Midtown in Milwaukee.

Deaconess Hospital currently has 16 Filipino interns and 20 residents on its staff.

Kenneth S. Jamron, executive director of the hospital, said, "Deaconess Hospital has had a long and mutually beneficial relationship with the leading medical schools of The Philippines. Since 1952, Deaconess has offered internship and specialty resident training to Filipino exchange medical visitors who have numbered between 20 and 30 annually. The complement has been as high as 38."

Mr. Jamron said the program is designed to make

the Filipino doctors more proficient physicians for their own nation.

Deaconess staff members who attended the dinner included Drs. Richard P. Jahn, Benjamin G. Narodick, Frank G. Stergiades, Roland E. Herrington, Weston D. Gardner, Yoshiro Taira, Edwin L. Bemis, Abraham Melamed, Richard Zellmer, George S. Woodward, James W. Fulton, Thomas Garland and Albino L. Settimi.

Members of the hospital's board of directors who attended were Rev. E. G. Gonser, Mr. Ernst H. Beck and Mr. William Stamm.

Wisconsin Regional Medical Program

T. A. Duckworth, senior vice-president and secretary of Employers Insurance of Wausau, has been reappointed chairman of the Advisory Committee of the Wisconsin Regional Medical Program, according to an announcement by Edmund Fitzgerald, Milwaukee, chairman of the Board and president of the organization.

New appointments to the Advisory Committee are: Leo E. Suycott, Milwaukee, president, Wisconsin Blue Cross Plan; Theodore Besser, administrator, Hudson Memorial Hospital, Hudson; and Mrs. Warren Lensmire, director of the Central Wisconsin E.O.C., Stevens Point.

The Advisory Committee consists of 41 individuals from all parts of the state in the fields of health, industry, education, government, labor, and the like. Under the law this Committee must review and approve all plans and operational projects before they can be considered by the federal government for financing grants.

Physicians who were reappointed for another one-year term are: *Drs. L. J. Van Hecke*, Milwaukee; *Dr. Peter L. Eichman*, dean of the University of Wisconsin Medical School, Madison; *James R. Hoon*, American Cancer Society, Sheboygan; *Dr. E. H. Jorris*, secretary and State Health Officer, Madison; *Dr. Gerald A. Kerrigan*, dean of Marquette School of Medicine, Milwaukee; *E. R. Krumbiegel*, commissioner of health, Milwaukee; *Russell F. Lewis*, president, Marshfield Clinic, Marshfield; *Hugh J.*

NURSING EDUCATION CHANGES FORECASTED

Major changes in nursing education were forecasted by a Columbia University educator during a recent day-long conference in Chicago for state medical societies liaison committees with nursing conducted by the American Medical Association's Committee on Nursing.

The conference was aimed at stimulating interest in and strengthening state level relationships . . . sharing experiences . . . understanding organized nursing and its goals . . . getting a comprehensive view of what has and is being done in the area of physician–nurse relationships at the state level . . . and in planning statewide conferences based on the national AMA–ANA conferences.

Forty-six state representatives, along with the Committee members and AMA staff personnel heard Eleanor C. Lambertsen, R.N., Ed.D., director of the Division of Nursing Education, Teachers College, Columbia U., discuss "Current Nursing Education and Practice." (Dr. George W. Hilliard of Milwaukee, a member of the State Medical Society's Commission on Hospital Relations and Medical Education, attended.)

In her presentation Doctor Lambertsen declared that the "health services available to the citizens of this nation are being adversely affected in both quantity and quality by shortages of physicians, nurses and other members of essential and emerging health disciplines."

Noting that the major problem is that of "talented manpower," Doctor Lambertsen emphasized that the future will see "more clearly defined areas of nursing practice and more clearly defined educational programs."

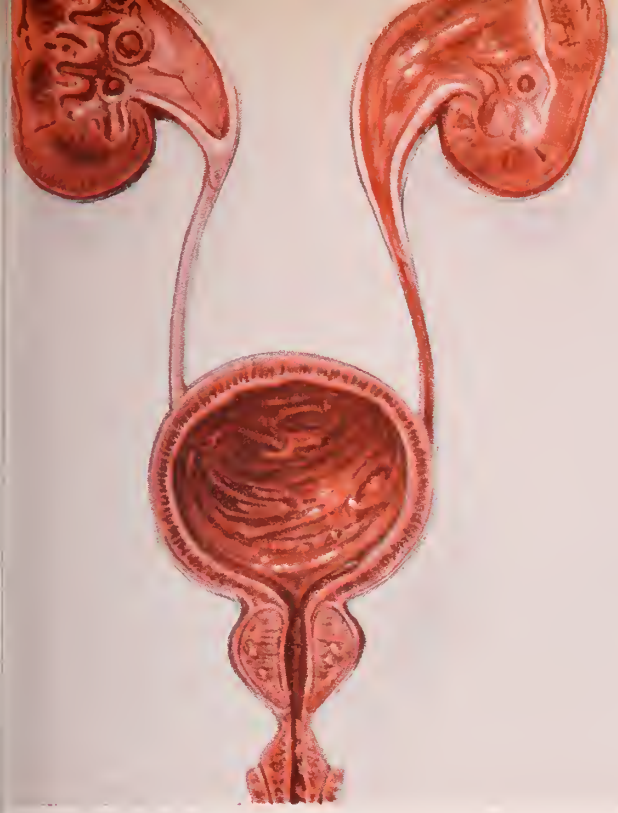
She said she "envisioned" three levels of workers—the clinical and general practitioners of nursing, and supportive nursing personnel.

"Attempts to solve the staffing problems of nursing service departments in all types of health institutions has been that of declaring that all types of education lead to the same ability for practice and therefore lead to indiscriminate assignments for patient care," said Doctor Lambertsen.

"The pattern coming into focus," she asserted, "is that of more clearly defined collaborative roles between nurses and physicians in practice which can only result in quality patient care services."

The joint approach was presented in a report on the "Development and Activities of a Joint Physician–Nurse Liaison Committee in the State of Idaho" by Sister M. Raphael, R.N., M.S., C.S.C., committee co-chairman and currently director of the School of Nursing, Holy Cross Hospital, Salt Lake City, and Joseph W. Marshall, M.D., a co-chairman of the Idaho study, from the Twin Falls Clinic and Hospital.

At the dinner meeting prior to this First National Conference, Milford O. Rouse, M.D., president of the AMA stressed the need for the two professions of medicine and nursing to work together more closely and effectively.



Diagnosis:

cystitis?
pyelonephritis?
pyelitis?
urethritis?
prostatitis?

in any case,
usually gram-negative*

Therapy:

two 500 mg. Caplets® q.i.d.
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nalidixic acid
a specific anti-gram-negative

eradicates most urinary tract infections...

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- "Excellent" or "good" response reported *in more than 2 out of 3* patients with either chronic or acute gram-negative infections.[1]

*As many as 9 out of 10 urinary tract infections are now caused by gram-negative organisms: E. coli, Klebsiella, Aerobacter, Proteus, Paracolon or Pseudomonas[2]... However, infections of the urethra and prostate caused by non-gonococcal gram-negative organisms are believed to be less prevalent.

Summary of prescribing information

Indications: Urinary tract infections in which gram-negative bacteria are predominant, particularly *Proteus, Escherichia coli, Aerobacter, Klebsiella,* and certain strains of *Pseudomonas*. Gram-positive bacteria are less sensitive to NegGram but favorable clinical results have been observed.

Warning: Use in Pregnancy. This drug is not recommended in the first trimester of pregnancy. However, it has been used in several patients during the last two trimesters without producing apparent ill effects in either mother or fetus.

Precautions: As with all new drugs, periodic blood and liver function tests are advisable during treatment longer than 1 or 2 weeks. **This drug should be used with caution in patients with liver disease, epilepsy, severe cerebral arteriosclerosis, or severe impairment of kidney function.** Because photosensitivity reactions have been reported in a small number of cases, patients should be cautioned to avoid unnecessary exposure to direct sunlight while receiving NegGram, and if a photosensitivity reaction occurs, therapy should be discontinued. The dosage recommended for adults and children should not arbitrarily be doubled unless under the careful supervision of a physician. Should bacterial resistance develop or additional nonsensitive strains emerge, other effective antibacterial agents should be added to or substituted for NegGram.

When testing the urine for glucose in patients receiving NegGram, Clinistix® Reagent Strips or Tes-Tape® should be used since other reagents may give a false-positive reaction.

Adverse reactions: Mainly mild nausea, vomiting, and other gastrointestinal disturbances; less frequently, sleepiness, drowsiness, weakness, headache, dizziness and vertigo, and rarely cholestasis, paresthesia, thrombocytopenia, leukopenia, or hemolytic anemia in patients with a deficiency in activity of glucose-6-phosphate dehydrogenase. Itching, pruritus, rash, urticaria, mild eosinophilia, reversible photosensitivity reactions primarily involving exposed surfaces, and reversible subjective visual disturbances (overbrightness of lights, change in visual color perception, difficulty in focusing, decrease in visual acuity and double vision), occurred occasionally. Reversible increased intracranial pressure with bulging anterior fontanel, papilledema, and headache has been observed occasionally in infants and children. Toxic psychosis and brief convulsions (the latter generally in patients with possible predisposing factors, and both usually associated with excessive dosage) have been recorded in rare instances.

Dosage and administration: ***Adults*—Four Gm. daily by mouth (2 Caplets® of 500 mg. four times daily) for one to two weeks. Thereafter, if prolonged treatment is indicated, the dosage may be reduced to two Gm. daily (1 Caplet of 500 mg. four times daily). *Children*—According to age and weight: approximately 25 *mg. per pound* of body weight per day, administered in divided doses.**

Note: The dosage recommended above for adults and children should not arbitrarily be doubled unless under the careful supervision of a physician. Until further experience is gained, infants under 1 month should not be treated with the drug.

How supplied:
- **For adults**—Buff-colored, scored Caplets of **500 mg.**, conveniently available in bottles of 56 (sufficient for one full week of therapy) and in bottles of 1000.
- **For children**—Caplets of **250 mg.**, available in bottles of 56 and 1000.

Before prescribing, please refer to complete prescribing information.

References: (1) Based on 23 clinical papers, 1512 cases. Bibliography on request. (2) Bush, I. M., Orkin, L. A., and Winter, J. W., in Sylvester, J. C.: Antimicrobial Agents and Chemotherapy—1964, Ann Arbor, American Society for Microbiology, 1965, p. 722.

Winthrop

Winthrop Laboratories, New York, N. Y. 10016

McLane, Wisconsin Heart Association, Fond du Lac; *Elwood W. Mason*, Milwaukee; *George B. Murphy, Jr.*, State Medical Society of Wisconsin, Gundersen Clinic, La Crosse; *Robert F. Purtell*, Milwaukee; *A. P. Schoenenberger*, Madison; *James M. Sullivan*, Milwaukee.

Dr. John S. Hirschboeck, Milwaukee, former dean of Marquette School of Medicine, is the executive head of the WRMP.

Southeastern Wisconsin Regional Center

A five-member subcommittee was appointed in November to draft an organizational plan for the southeastern Wisconsin regional medical center. The committee is headed by Edward J. Logan, administrator of Milwaukee Children's Hospital and president of the Wisconsin Hospital Association.

Others appointed to the subcommittee are *Dr. Gerald A. Kerrigan*, dean of the Marquette School of Medicine; Joseph F. Heil, Sr., president of the Heil Co.; *Dr. James M. Sullivan*, a past president of The Medical Society of Milwaukee County and a councilor to the State Medical Society of Wisconsin; and Symond R. Gottlieb, executive director of the Hospital Area Planning Committee, Inc.

Appointments were made by Delwin C. Jacobus, chairman of the executive committee of the medical center steering committee at the Memorial Center.

The subcommittee will plan a medical center with Marquette School of Medicine and Milwaukee County General Hospital as its nucleus. Other hospitals affiliated with the medical school, including Milwaukee Children's, also will participate.

Mr. Jacobus also named J. Martin Klotsche, chancellor of the University of Wisconsin–Milwaukee, to the executive committee. Mr. Klotsche is the only UW–M representative on the steering committee.

"Otomobile" to Travel State for Hearing Tests

The first of its kind in the nation—an otomobile—has been designed for field testing of children with hearing difficulties. The mobile field unit, which will be used throughout Wisconsin, contains a soundproof room with equipment for detailed audiometric testing and a fully equipped examining room for the otologist who gives diagnostic ear, nose, and throat examinations to children who are believed to have significant hearing impairments. The otomobile was designed for the Wisconsin Hearing Conservation Program of the Bureau for Handicapped Children.

Affiliate with Curative Workshop

Milwaukee Children's Hospital and Marquette School of Medicine have affiliated with the Curative Workshop of Milwaukee, according to an announcement in November. The arrangement is intended to strengthen the medical, rehabilitation, and teaching programs offered by the institutions and avoid needless duplication.

* * *

THE 25.8 MILLION veterans now in civil life range in age from teenagers to over 90. Their average age is 44 years, according to the Veterans Administration.

Wisconsin Division of Health Studies Hospital Demand and Use

An extensive study of hospital use and of demand for hospital facilities in Wisconsin is being conducted by the Wisconsin Division of Health, formerly the State Board of Health. Participating in the study are 161 short term hospitals, representing 21,831 beds, 55,000 patient discharges per month. When the study is completed, much more will be known about hospitalized patients, where they are from, how old they are, how bills are paid, and as to where they are discharged.

Information secured from discharge records for the months of October 1967 and March 1968 will form the basis of the survey. These data will be helpful in planning health care services. The study is being financed by a U. S. Public Health Service grant under the Comprehensive Health Planning Act. The study may also provide a basis for appraisal of the impact of Medicare and Medicaid on the general hospitals of the state.

The survey will coordinate discharge information from hospitals which have established their own data processing for discharges either independently or in a group and those which purchase medical audit programs, with those hospitals which do not have established data processing. The survey will produce information helpful to the state agency planners in order to establish priorities and estimate the need for grants under the Hill–Harris (Hill–Burton) hospital construction and modernization programs.

The data obtained from the study will be tabulated into hospital service areas for planning purposes. The basic information, which is coded to protect the identity of the patient, will be available to the participating hospitals. Each hospital will be furnished a copy of its own data and each will retain complete control of the information.

MEMBERSHIP REPORT AS OF OCTOBER 30, 1967

SOCIETY RECORDS

NEW MEMBERS

Allen, Maurey, 1300 University Ave., Madison, 53706
Azcueta, Ester S., 811 E. Wisconsin Ave., Milwaukee 53202
Barnes, Haldor Peter G., 5510 Medical Circle, Madison 53711
Beck, James Paul, 1912 Atwood Ave., Madison 53704
Becker, Robert M., 3414 Monroe St., Madison 53711
Chosy, Louis W., 1300 Univcersity Ave., Madison 53706
Collins, Richard A., 2900 W. Oklahoma Ave., Milwaukee 53215
Danocup, Roberto J., 320 South 70th St., Milwaukee 53214
Dortzbach, Richard K., 1300 University Ave., Madison 53706
Draheim, John H., 300 Terraview Dr., Green Bay 54301
Gimenez, A. R., 270 E. Marquette St., Berlin 54923
Goerke, Robert F., 811 E. Wisconsin Ave., Milwaukee 53202
Hansen, Raymond L., 630 South Central Ave., Marshfield 54449
Herhahn, Frank T., 5129 Flambeau Rd., Madison 53705
Huewe, Douglas A., 6055 N. 40th St., Milwaukee 53209
Jaramillo, Carlos A., 1107 14th Ave., Monroe 53566
Konetzki, Wayne H., 403 North Grand Ave., Waukesha 53186
Korbitz, Bernard C., 1300 University Ave., Madison 53706
Locher, Charles J., 1930 East Bradford Ave., Milwaukee 53211
Lopez, Basilio, 1545 South Layton Blvd., Milwaukee 53215
Mills, John M., 128 E. Walnut St., Green Bay 54301
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Schneider, J. Morton, 1300 University Ave., Madison 53706
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Stinson, H. Keith, 630 South Central Ave., Marshfield 54449
Toohill, Robert J., 5757 W. Oklahoma Ave., Milwaukee 53219
Vergamini, Jerome C., 1141 Petra Place, Madison 53713
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Bach, Mark J., Milwaukee, to Route 1, Port Washington 53074
Bassewitz, P. P., P. O. Box 464, Sheboygan 53081
Bates, Donald E., Fort Atkinson, to 4745 East Hampton, Tucson, Ariz. 85716
Bond, John T., Hales Corners, to 1445 South 32nd St., Milwaukee 53215
Brown, Dwight H., 17000 West North Ave., Brookfield 53005
Buerger, Edward J., Milwaukee, to 116 Windsor, Waukesha 53186
Crittenden, J. Jay, Milwaukee, to USN Hospital Yokuska, APO 96662, San Francisco, Calif. 94100
Dempsey, Kenneth J., N88 W16951 Main St., Menomonee Falls 53051
Garry, Mark W., 6200 West Bluemound Rd., Milwaukee 53213
Gruender, J. E., Whitefish Bay, to 505 West Silver Spring Drive, Milwaukee 53217
Hughes, John B., 2105 Bowen St., Oshkosh 54901
Kappus, Harold C., Kenosha, to Veterans Administration Hospital, Tucson, Ariz. 85713
Koenig, Erwin, 2109 Westchester Rd., Madison 53711
Lyons, Charles R., 2000 East Murdock Ave., Oshkosh 54901
Matus, Simon, Central Islip, New York, to Box 5 Station A, Ogdensburg, New York 13669
Meyer, Robert J., 108 Mary Lynn Ave., Spring Valley 54767
Montenegro, Jose V., 4434 West Capitol Dr., Milwaukee 53216
Motamedi, Naghi, 845 North 12th St., Milwaukee 53233
Nash, C. B., 103 South Jackson St., Janesville 53545
Otterson, W. N., USA Mc Ryukyu Islands, APO 96331 San Francisco, Calif. 94100
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Rosmann, Hermann K., Hayward, to 209 Fuller Lane, Winnetka, Ill. 60093
Sheldon, E. O., Jr., 2712 Marshall Court, Madison 53705
Stein, Bernhardt E., 4510 Regent St., Madison 53705
Terry, John W., 4383 North 27th St., Milwaukee 53216
Tibbetts, Palmer G., 3602 South 92nd St., Milwaukee 53228
Turner, Lewis, III, 2525 63rd St., Kenosha 53140
Walters, Harry G., 1711 Shoop St., Racine 53404
Weisenthal, Charles L., 2040 West Wisconsin Ave., Milwaukee 53233
Wiesen, Richard L., Milwaukee, to 2679 Berkshire Rd., Augusta, Ga. 30904

DEATHS

Thackeray, Robert C., Racine County, Aug. 5, 1967
Sandgren, Gilbert R., Oconto County, Oct. 5, 1967
Wilets, Jack C., Milwaukee County, Oct. 5, 1967
McDonald, C. F., Milwaukee County, Oct. 7, 1967
Wagner, Paul C., Milwaukee County, Oct. 11, 196
Wright, Robert S., Racine County, Oct. 13, 1967

* * *

RETIREES EFFECTIVE Dec. 31, 1967, should consult with their Social Security District Office in advance of actual retirement date.

★

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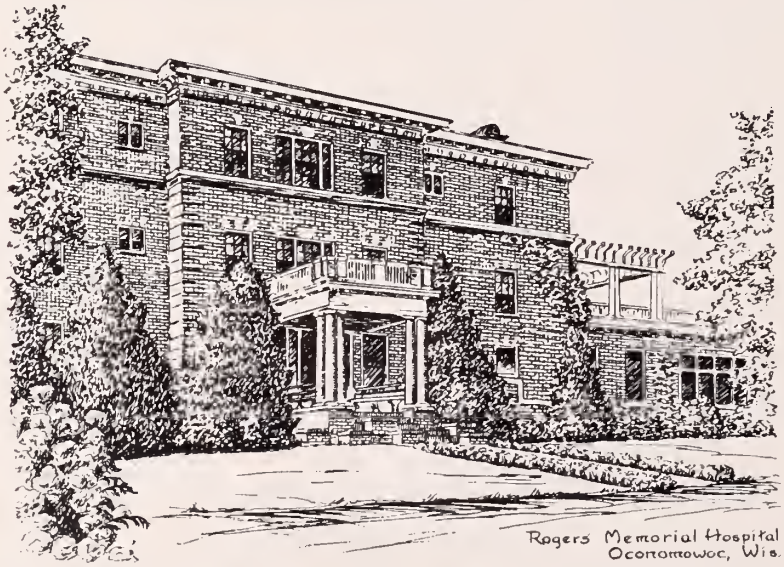

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List of Officers and Scheduled Meetings of County Medical Societies (Continued)

COUNTY	PRESIDENT	SECRETARY	MEETING DATE
Iowa	David R. Downs Dodgeville	H. P. Breier Montfort	Second Tuesday
Jefferson	Robert G. Handeyside 210 Madison Ave. Fort Atkinson	Stanley Vognar 210 Madison Ave., Ft. Atkinson	Third Thursday*
Juneau	J. H. Vedner Mauston	Jack Strong Mauston	Second Tuesday Hess Clinic in Mauston
Kenosha	Walter C. Rattan 6530 Sheridan Rd. Kenosha	Fredrick Wood, Jr. 6530 Sheridan Rd. Kenosha	First Thursday* Elks Club
La Crosse	Wm. B. Gallagher 312 State St. La Crosse	Gunnar A. Gundersen, Jr. 1836 South Ave. La Crosse	Third Monday
Lafayette	R. E. Hunter Argyle	L. L. Olson 504 Wells St., Darlington	Last Tuesday
Langlade	John E. Garritty Antigo	Donald V. Blink 837 Clermont, Antigo	First Monday
Lincoln	James F. Bigalow 712 E. 2nd St., Merrill	James S. Janowiak 716 E. 2nd St., Merrill	
Manitowoc	T. H. Rees 104 North 8th St. Manitowoc	M. A. Jacobi 2300 Western Ave. Manitowoc	Last Thursday
Marathon	Gregory J. Bachhuber 614—3rd Ave. Wausau	Gordon L. Backer 630 First St., Wausau	
Marinette–Florence	C. L. Blahnik 600 Oconto Ave., Peshtigo	K. G. Pinegar 516 Houston, Marinette	Third Wednesday St. Joseph's Hospital
Milwaukee	Christopher, R. Dix 2040 W. Wisconsin Ave. Milwaukee	William L. Coffey, Jr. 536 W. Wisconsin Ave. Milwaukee Mr. J. O. Kelley, Ex. Sec. 756 N. Milwaukee, Milw.	Second Thursday
Monroe	Dewitt Beebe Sparta	E. O. Lukasek 110 E. Franklin St.,, Sparta	Third Monday
Oconto	F. W. Klutzow Main St., Gillett	Kenneth L. Strebe 134 N. Main St., Oconto Falls	
Oneida–Vilas	I. Nik Nevin 134 N. Oneida Ave. Rhinelander	Marvin Wright 1020 Kabel Ave., Rhinelander	Monthly
Outagamie	James E. Gmeiner 1260 Valley Rd., Appleton	G. J. Petersen 506 E. Longview Dr. Appleton	Third Thursday* Elks Club
Ozaukee	George F. Savage 173 Prospect St. Port Washington	Philip W. Wallestad 502 W. Jefferson Port Washington	
Pierce–St. Croix	L. B. Torkelson Baldwin	C. A. Olson Baldwin	Third Tuesday
Polk	Jack R. Inyart Osceola	D. F. Schwab Frederic	Third Thursday 7:00 p.m.
Portage	J. R. Erickson 211 Water St. Stevens Point	Albert Kohn 313 N. Fremont Stevens Point	
Price–Taylor		Walther W. Meyer 410 S. Second, Medford	Last Saturday, Feb., May, Aug., and Nov.
Racine	William J. Madden 1841 Wisconsin Ave. Racine	Elizabeth A. Steffen 734 Lake St. Racine Mr. G. N. Geraghty 600 Villa Street, Racine Exec. Sec.	Third Thursday
Richland	Roy C. Glise 890 East Kinder St. Richland Center	L. M. Pippin 1313 W. Seminary St. Richland Center	First Thursday Richland Hospital
Rock	Paul K. Odland Rt. 1, Roger Heights Janesville	William A. Pruett 2031 Riverside Dr., Beloit	Fourth Tuesday
Rusk	Joseph E. Murphy 403 East Miner Ave. Ladysmith	Wm. B. A. J. Bauer Ladysmith	First Tuesday
Sauk	Robert G. Hansel 407 Oak Street Baraboo	John T. Siebert 101 Fourth St. Baraboo	Second Tuesday*
Shawano	Donald W. Schulz 139 S. Main St., Shawano	A. J. Sebesta P. O. Box 311, Shawano	Third Wednesday
Sheboygan	Burnell F. Eckardt 1226 North Eighth St. Sheboygan	Robert A. Keller 718 South 27th St. Sheboygan	First Thursday
Trempealeau–Jackson–Buffalo	Charles F. Meyer Box 180 Independence	Eugene Krohn 221 Main St. Black River Falls	Fourth Tuesday
Vernon	Thomas Boston 840 Water Ave., Hillsboro	T. Zimmermann 100 W. Melby St., Westby	Last Wednesday
Walworth	Wm. C. Woods 607 Walworth Ave., Delavan	Boyd C. Hindall 717 Geneva St., Lake Geneva	Second Thursday*
Washington	W. E. Scheunemann 626 Cedar St. West Bend	R. F. Sorensen 633 14th Ave., West Bend	Fourth Thursday
Waukesha	Richard G. Frantz 1111 Delafield St., Waukesha	D. P. Nachazel, Jr. 102 E. Main St., Waukesha	First Wednesday
Waupaca	Harry S. Caskey Clintonville	Joseph W. Weber 322 N. Water St. New London	
Winnebago	Frederick H. Smith 116 S. Commercial St., Neenah	Richard C. Wolfgram Route 4, Box 746, Oshkosh	First Thursday
Wood	J. W. Schaller 184 2nd St. N., Wis. Rapids	John L. Burns, Jr. 630 S. Central, Marshfield	Four times a year

* Except June, July and August.

The views expressed in the articles on legal medicine are those of Society attorneys, or other authors, and do not necessarily represent Society policy; and in some cases represent areas in which no policy exists.

—Statement authorized by House of Delegates, Oct. 22, 1966

Legal Problems of Medical Societies: The Darling Case

By FRANK M. PFEIFER, Esq., Springfield, Illinois

INTRODUCTORY NOTE

SINCE THE DECISION became final in November 1965, the ruling announced by the Supreme Court of Illinois in the case of *Darling v. Charleston Community Memorial Hospital* has created great interest on the part of physicians and hospital administrators. The text which follows was presented by Mr. Pfeifer at the Legal Conference for Medical Society Representatives, sponsored by the Law Department, American Medical Association, April 15–16, 1966, Chicago.

* * *

I THINK WE can say that the principal holding in this case was that a hospital is liable for not providing proper *medical supervision* when such supervision is needed.

First of all, the facts. The plaintiff in this case was a college student at one of the Illinois universities. He was 18 years of age and suffered a broken leg while playing football. He was taken to the hospital in Charleston and the doctor on emergency was called and provided treatment and continued to treat him throughout his stay at this hospital. The factual situation as shown by the evidence in the trial court is unbelievably bad. Anyone reading this case would undoubtedly come to the conclusion that there was complete and absolute negligence on the part of the attending physician.

The leg was set and then placed in a tight plaster cast with no padding. A heat cradle was placed on the cast and left there for several days. Immediately after the application of the cast, the boy began complaining of pain which he continued to do throughout his stay in the Charleston Hospital. The principal treatment that was given was medication to ease and kill the pain. The testimony reveals that all through his stay in this hospital the patient was begging for someone to help him. There is testimony that the stench in the room was almost nauseating. When the cast was removed the leg was cut in several places and thereafter, infection set in. Ultimately, a gangrenous condition developed and the boy was then taken from the Charleston Hospital to Barnes Hospital in St. Louis where, after several operations in an attempt to save the leg, it had to be amputated.

I believe we will all agree that a bad factual situation frequently produces bad law, and I would say that this case follows that rule. In the decision in the appellate court, the court devoted some 77 pages to this opinion, and most of it is taken up by the factual situation. The doctor in question settled out of court for $40,000. The verdict of the jury was a judgment against the hospital for $150,000. This was reduced by the court by the $40,000 which had previously been obtained from the carrier for the doctor.

Both our Appellate and Supreme Courts in their decisions commented upon the fact that the doctor in question had settled out of court and had settled for $40,000. I read in this, in both of these decisions, that had the courts had the opportunity, they would undoubtedly have held against the doctor.

This is the first time that we have had a decision in the State of Illinois requiring a hospital to provide proper medical supervision and holding it liable when such supervision was not provided. Neither have I been able to find any similar decisions in other jurisdictions. It may have been due to the factual situation in this case that the courts were searching for reasons to grant recovery but whatever the reason may be the decision establishes law in Illinois, which very well may extend to other jurisdictions.

A rather important point in the case is the fact that the court allowed certain documents to be introduced in evidence, which documents were: (1) The Standard for Hospital Accreditation of the American Hospital Association; (2) The Hospital Regulations adopted by the State Department of Public Health under the Illinois Hospital Licensing Act, and (3) The By-Laws of the Charleston Community Memorial Hospital. The jury was allowed to examine all of these documents in order to determine the standard of care and diligence which should

Mr. Pfeifer is Counsel for the Illinois State Medical Society

have been performed by the hospital and what the hospital knew or should have known.

The Supreme Court of Illinois of this point said:

> "The conception that the hospital does not undertake to treat the patient, does not undertake to act through its doctors and nurses, but undertakes instead simply to procure them to act upon their own responsibility, no longer reflects the fact. Present-day hospitals, as their manner of operation plainly demonstrates, do far more than furnish facilities for treatment. *They regularly employ on a salary basis a large staff of physicians, nurses and interns, as well as administrative and manual workers and they charge patients for medical care and treatment, collecting for such services, if necessary, by legal action.* Certainly, the person who avails himself of 'hospital facilities' *expects that the hospital will attempt to cure him, not that its nurses or other employees will act on their own responsibility.* (Citing cases.) The Standards for Hospital Accreditation, the state licensing regulations and the defendant's bylaws demonstrate that the medical profession and other responsible authorities regard it as both desirable and feasible that a hospital assume certain responsibilities for the care of the patient." [Italics supplied by Editor]

Two of the important issues submitted to the jury for decision were: (1) Was the hospital negligent in failing to have a sufficient number of trained nurses for bedside care of all patients at all times capable of recognizing the progressive gangrenous condition of the patient's right leg and of bringing the same to the attention of the hospital administration and the medical staff so that adequate consultation could have been secured and such conditions rectified; and (2) Was the hospital negligent in failing to require consultation with or examination by members of the hospital surgical staff skilled in such treatment rendered to the patient and to require consultants to be called in as needed.

The court in connection with these two issues stated:

> "We believe that the Jury verdict is supportable on either of these grounds. On the basis of the evidence before it, the Jury could reasonably have concluded that the nurses did not test for circulation in the leg as frequently as necessary; that skilled nurses would have promptly recognized the condition that signaled a dangerous impairment of circulation in the plaintiff's leg and would have known that the condition would have become irreversible in a matter of hours. *At that point, it became the nurses' duty to inform the attending physician, and if he failed to act, to advise the hospital authorities so that appropriate action might be taken. As to consultation there is no dispute that the hospital failed to review the physician's work or require a consultation.*" [Italics supplied by Editor][1]

The language of the court as to the duties of the nurses, I believe, becomes of particular importance and significance to both physicians and hospitals. This very well may mean that we are going to get some second guessing of physicians on the part of the nurses but be that as it may, the duty of the nurses is considerably enlarged by this decision.

We have seen a tendency, not only in malpractice cases but in all types of personal injury of an increase in the number of cases brought, an increase in the number of judgments obtained, and an increase in the amount of the judgments. One out of every seven physicians now has a malpractice suit brought against him sometime during his practice and this instance is on the increase. The *Darling* case will undoubtedly cause more malpractice suits to be filed in Illinois and the suits will now probably be jointly brought against both the physician and the hospital. It is further my thought that this case will cause an increase in the number of suits filed in states other than Illinois, especially if this decision is adopted in other jurisdictions, which very well could happen.

The Supreme Court of Illinois, for the first time in this case, held that expert medical witnesses can be cross-examined concerning the views of recognized authorities in the particular field in question.

The question now becomes: What do we as attorneys for state medical associations advise our clients in light of the decision in the *Darling* case? It would appear that the following should be given upon a minimal basis:

1. Carry adequate malpractice insurance.
2. Physicians must conduct their practice in hospitals so that they comply with and live up to the standards for hospital accreditation of the American Hospital Association, the hospital regulations adopted by the State Department of Public Health under the Hospital Licensing Act or comparable regulations in other states and the bylaws of the hospital in which they are practicing.
3. Keep up on modern medicine in the fields in which they practice so that they are conversant with and use the latest proven developments.
4. Call in specialists whenever the need arises.
5. Automatic consultation in all serious cases—it cannot be disputed that any physician being called on to defend his treatment in court is in a much better position if he can also bring forth as a witness the physician who reviewed the case and consulted with him; or the specialist in a given field called in by him. These procedures, I believe, would tend to greatly reduce the number of malpractice cases filed and the judgments obtained.
6. Hospital records and those of the physician should be kept in such manner and in such detail as will be meaningful and show that adequate medical procedures were followed. It should be remembered that frequently cases are not filed until some time after the alleged injury took place and sometimes do not come to trial for several years thereafter.
7. All cases should be treated in such a manner and records kept as if the case would result in a malpractice suit and would not come to trial for a considerable period of time after the alleged injury had taken place.

If the above recommendations are followed, it would undoubtedly be time-consuming but I believe it is the only way in which the growing trend in malpractice cases and recoveries can be reversed.

REFER CHILD PLACEMENT CASES TO THESE AGENCIES

LICENSED CHILD WELFARE AGENCIES:

Wisconsin Lutheran Child and Family Service, Inc., 6870 North 76th Street, Milwaukee 53223.

*Children's Service Society of Wisconsin, 610 North Jackson, Milwaukee 53202.

Catholic Social Services of the Archdiocese of Milwaukee, Inc., 207 East Michigan Street, Milwaukee 53202.

Catholic Charities Bureau, 1209 Hughitt Ave., Superior 54881.

Catholic Social Service, Inc., 128 South Sixth Street, La Crosse 54601.

Catholic Social Service, 25 S. Hancock, Madison 53703.

Green Bay Diocese Apostolate (Catholic), 131 South Madison Street, Green Bay 54305.

Lutheran Children's Friend Society, 8138 Harwood Avenue, Wauwatosa 53213.

Lutheran Social Services of Wisconsin and Upper Michigan, 3126 West Highland Boulevard, Milwaukee 53208.

Jewish Family and Children's Service, 2218 North Third Street, Milwaukee 53212.

PUBLIC AGENCIES:

*Wisconsin Division for Children and Youth, Room 384, State Office Bldg., Madison 53702.

*Milwaukee County Department of Public Welfare, Child Welfare Division, 1220 West Vliet Street, Milwaukee 53205.

LICENSED MATERNITY HOMES:

Lutheran Maternity Home, 1910 South Ave., La Crosse 54601.

*Booth Memorial Hospital, 6306 Cedar Street, Wauwatosa 53213.

Rosalie Hall Maternity Home (Catholic), 1233 North 23rd Street, Milwaukee 53205.

St. Francis Maternity Residence (Catholic), 11th and Market Streets, La Crosse 54601.

Marian Hall (Catholic), 1725 Dousman Street, Green Bay 54303.

Fees for care in licensed maternity homes vary from $150 and up, depending on length of stay, covering prenatal care, confinement, and care after the child is born. Counseling services for unwed parents, both before and after the birth of the child, are provided by social agencies.

* Nondenominational.

Some people have suggested that this decision means that hospitals are now going to be engaged in the practice of medicine.[2] I do not agree with this interpretation but I do think this decision means that a hospital must do all it can to prevent negligence on the part of all persons having to do with the patients, if they are to escape liability. While the physician was not involved in this case as he had settled out of court, this decision will probably increase the incidence of malpractice cases against physicians as well as hospitals and means that both must be able to prove that they have exercised a high degree of care.

EDITOR'S NOTES:

1. In the judgment of the Society attorneys, the wording italicized in the quoted paragraphs of the court opinion is extreme, and, to the extent indicated below, inaccurate for Wisconsin. They point out that hospitals located in Wisconsin which "regularly employ on a salary basis" any physician other than a resident, an administrator or a coordinator of postgraduate medical education, or which charges "patients for medical care and treatment", except as the agent of a licensed physician on the medical staff, would be acting in violation of the Fee Splitting law of this state.

They also observe that no hospital can "cure" anyone, notwithstanding the statement by the Illinois court that today's patient "expects that the hospital will attempt to cure him." A hospital is a *legal*, not a *natural* person. As a consequence it can act only through human agents and can do nothing in itself.

2. Attorneys for the Society advise that the Illinois court sustained a jury finding in the above case that the failure of the hospital to (1) review the physician's work, or (2) require a consultant, was negligence on its part. They also advise that because of the newness of the case and the absence of similar decisions outside of Illinois, it is not possible to prophesy how another court might react to analogous facts.

The Society's attorneys further note that by imposing on the hospital administration a review of the physician's management of a case and a requirement of consultation in an undisclosed number of cases, both as a condition of avoidance of legal liability for negligence, the court is, in effect, asking hospital administration and management to make medical judgments. This seems completely unrealistic since very few hospital administrators or directors are trained in medicine and in a large number of hospitals no administrator or director has such training. Had the court intended that these medical responsibilities be those of the medical staff it could have said so clearly or at least inferentially. Not having done so, the decision leaves in doubt the court's real intention unless, possibly, to uphold the jury finding of negligence, and the substantial damages assessed against the hospital.

Medical Evaluation of Driver Impairment

THE DRIVER should be required to submit evidence of his functional capacity if he has a medically definable physical condition or process which may give rise to a lapse of consciousness, loss of postural control, loss of vision while driving, or any other physical or mental impairment that may be objectively identified that results in loss of ability to control his vehicle with safety. *It is the symptom which is the matter of concern and not the condition or process per se.*

A. BASIC PRECEPTS

1. Safe motor vehicle operation requires coordination of a complex series of sensory inputs, judgmental decisions, and neuromuscular motor responses. Driver impairment may involve any of these areas of human function.
2. Driver impairments may be temporary or permanent—deteriorating, static, or improving. Permanent impairments may warrant revocation of the operator's license; temporary impairments usually must be managed by education of the driver to recognize his limitations so that he may modify his driving as necessary.
3. The physician in his evaluation of possible driver impairment must frequently make judgments which are unpopular with the driver who is faced with possible loss of his operator's permit; but the revocation decision is not made by the physician, this responsibility rests with the Motor Vehicle Department.
4. There are many apparently serious physical impairments to which satisfactory compensatory adjustments may be effected and drivers with these problems are frequently able to demonstrate competence in a driving test.
5. Persons subject to unexpected, sudden lapses of consciousness or of neuromuscular control cannot be considered safe drivers and must be urged to give up driving, at least until the underlying cause is under medical control. Present law in Wisconsin does not provide for physician reporting of these "impaired" drivers.
6. There is no evidence that age alone is a justifiable criterion for definition of ability to drive safely. Many young (inexperienced) drivers have impairment of their driving abilities by reason of immature judgment; some elderly drivers have driving impairment by reason of sensory and/or motor deficits resulting from the aging process.
7. Many driver impairments are of such a nature that safe motor vehicle operation may be reasonably assured in restricted traffic situations —i.e., daylight hours, low to moderate speeds, low traffic volume.
8. Many drugs, including alcohol, produce temporary impairments which may cause severe functional limitation; all driving age patients using certain drugs—especially tranquilizers, sedatives, narcotics, antihistamines, stimulants, and mood modifiers—must be warned of the possible dangerous effects of the medicines and advised to restrict their driving accordingly. NOTE: Attention is called to the *potentiating effect of alcohol* in combination with many of these drugs.

B. SPECIFIC MEDICAL CONDITIONS OR AREAS

DIABETES . . . The uncontrolled diabetic should be advised not to drive because of the possible sudden development of disabling complications.

HYPERINSULIN STATES . . . Individuals subject to attacks of faintness, giddiness, or unconsciousness should not drive.

THYROID DISEASE . . . Uncontrolled thyrotoxicosis should be considered a contraindication to driving, also severe myxedema and cretinism.

MUSCLE WEAKNESS AND HYPOTONIA . . . Individuals with these symptoms of various metabolic and/or neurologic conditions may need to be advised to restrict or stop their driving.

CARDIOVASCULAR DISEASE . . . Uncontrolled conditions in which sudden death, lapse of consciousness, or pain sufficient to cause loss of control of the vehicle should preclude motor vehicle operation.

CEREBROVASCULAR DISEASE (INCLUDE HYPERTENSION AND VASOMOTOR INSTABILITY . . . Patients with inadequate blood flow to the brain are likely to have attacks of syncope or dizziness (vertigo) and should be advised not to operate a motor vehicle.

VISION . . . Optimally corrected vision poorer than 20/40 in the better eye should be considered to be cause for restricted driving; corrected vision of at least 20/70 should be required for restricted driving privileges. Color blindness is not now considered to be of any great consequence to safe driving.

Prepared by the Division on Safe Transportation of the State Medical Society's Commission on State Departments and approved by the Council, Oct. 21, 1966.

HEARING . . . Hearing loss can be compensated for to enable safe driving. Present state law requires outside rear-view mirrors for these drivers.

SKELETAL (ORTHOPEDIC) DEFECTS . . . Acute musculoskeletal injuries frequently produce temporary driver impairment; chronic and permanent defects frequently may be compensated for by special mechanical devices and should be subjected to the test of "demonstrated competence" to drive safely.

CONVULSIVE DISORDERS . . . Current Wisconsin Statutes are considered to provide adequate safeguards for the general highway public as well as to allow the privilege of the highway to the person whose condition is controlled. Night driving may present particular hazards of "photic stimulation of seizures" of which the driver should be advised.

NARCOLEPSY . . . Persons with this condition should be allowed to drive if it is controlled by medication and medical supervision is maintained.

MENTAL DEFICIENCY . . . Drivers need to have the intellectual capacity, demonstrated by testing, to interpret the basic traffic control signs and to react appropriately. This determination is a function of the licensing authority and borderline applicants should probably have restricted privileges.

MENTAL AND EMOTIONAL DISTURBANCES . . . There are presently no known testing procedures which can reliably predict a person's ability to drive safely or to indicate a significantly hazardous emotional instability such as to warrant consideration for license revocation; certainly many mentally ill persons have periods of functional impairment but these, for the noninstitutionalized person, should be handled as are other temporary impairments. Individuals who have had changes in personality, alertness, ability to make decisions, or actual loss of motor or sensory power, should not be allowed to drive until the condition is stabilized and competence can be demonstrated by appropriate testing.

ALCOHOLISM . . . Chronic alcoholics should not drive until such time as there is reasonable medical evidence that the condition is controlled.

C. SUMMARY

The presence of certain physical pathologic processes or conditions should give rise to a question of fitness to drive. This brief guide has been prepared in an effort to inform the examining physician of currently accepted concepts of anatomic and functional aspects of driver impairment.

D. SUGGESTED REFERENCES

1. AMA Medical Guide for Physicians in Determining Fitness to Drive a Motor Vehicle, 1959.
2. Proceedings National Conference on Medical Aspects of Driver Safety and Driver Licensing, 1964 (out of print).
3. Special Report—Medical Aspects of Driver Limitation, JAMA, Feb. 1, 1964, p. 376.
4. Drugs and Driving, JAMA, Jan. 31, 1966, pp. 376–379.

DRIVERS' LICENSES FOR EPILEPTICS

A person subject to epileptic seizures may be licensed to drive a motor vehicle in Wisconsin on a temporary basis if:

(1) He submits with his application a certificate from a licensed physician recommending that a temporary driver's license be issued, and
(2) He is otherwise qualified to obtain a license.

The certificate is a form prepared by the Motor Vehicle Department and is designed to elicit medical information necessary to determine whether permitting the epileptic to drive would be a hazard to public safety.

To retain his license the epileptic must present a new certificate every six months.

The issuance of a temporary license is discretionary with the Motor Vehicle Department. A denial may be reviewed, however, by a special board of five members. Four of these members are designated by the president of the State Board of Health.**

Reference: Section 343.09, Wisconsin Statutes, 1965.

** The fifth member is the Commissioner of the Motor Vehicle Department, and he and any two of the other members constitute a quorum.

Medical Staffing of Emergency Rooms; Legal and Ethical Considerations

By WAYNE E. STICHTER, Juris Doctor, Toledo, Ohio

THE TREMENDOUS increase in the past few years in the number of cases treated in the emergency rooms of hospitals, combined with the increasing difficulty in securing personnel, professional and non-professional, to staff the emergency department, has served to focus attention upon a number of questions with respect to the staffing and operations of the emergency department:

1. Legal questions affecting the hospital and its authority over the operations of the emergency room.
2. Legal and ethical questions affecting the medical profession generally and particularly those physicians who render emergency room care.
3. Practical questions affecting the hospital, the medical profession, and the public.

In order that we may understand the nature and extent of these problems and to discuss them intelligently, it is important, so it seems to me, to have an understanding of the facts that give rise to these problems—to ascertain the causes for the critical problems existing today in connection with the rendition of high quality medical care in the emergency department of a hospital.

Years ago the emergency room of a hospital was just what the name implies—a room in the hospital for the treatment of emergency cases, a room for providing immediate medical services for acute traumatic problems and life endangering situations. The public had not yet gotten into the habit of going to the emergency room for the treatment of a minor illness or injury; rather, the patient sent for or went to his own physician. Years ago, interns and residents in training in the hospital were generally adequate in number and sufficiently competent to handle these emergency cases—with the help, of course, of the attending physicians or members of the medical staff who might be summoned to the emergency room.

SITUATION TODAY

What is the situation today? Since World War II there has been an astronomical upsurge in the number of visits to the emergency room; indeed, surveys indicate that in the past five or six years there has been an increase—on the average—of 400 to 600 per cent in the number of cases treated in the emergency room. Concurrently with this astounding increase in the number of emergency room cases, there has been an actual decline in the number of interns and residents available for staffing of the emergency room.

We all know, of course, that in these same years there has been quite an increase in the number of traumatic injuries due to automobile accidents and perhaps other types of accidents (there has been an actual decline in industrial accidents). However, this increase in accidental injuries cannot possibly account for the great increase in the number of emergency room visits. The most plausible explanation for this large increase in emergency room visits lies in the fact that the hospital emergency room has gradually been converted into what one doctor has appropriately called "a neighborhood drop-in clinic." Recent statistical surveys reveal that of the total number of cases brought to the emergency room 50 to 80 per cent can be definitely characterized as non-emergency cases. These non-emergency cases, involving as they do minor illnesses or minor injuries, could just as well be taken care of in the physician's office. If this great volume of non-emergency cases could be diverted away from the emergency room, the present strain on the facilities and personnel of the emergency room would be greatly relieved, and the job of rendering prompt and adequate care to true emergency patients would be greatly facilitated.

WHY THE EMERGENCY ROOM?

Why does a patient with a minor illness or injury go to the hospital emergency room instead of to the doctor's office? Various reasons have been ascribed to this change in the pattern of cases brought to the emergency room. I shall mention only a few that have been advanced:

1. There are fewer general practitioners available for family care.
2. The patient may not have a family doctor.
3. The patient may not know what kind of a specialist to call to take care of his particular complaint.
4. Doctors are not always available at their offices whereas the hospital emergency room is always open.
5. The necessity of an appointment with the private physician.

Text of an address delivered by Mr. Stichter at the American Medical Association Legal Conference for State Medical Society representatives and executive secretaries, in Chicago on April 16, 1966.

Mr. Stichter is Legal Counsel for the Ohio State Medical Association.

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6. The automatic transportation of injury cases, however slight, to the emergency room (someone calls an ambulance and the ambulance driver automatically transports the patient to the hospital whether or not directed by the patient or someone in his behalf to do so).

7. A general belief that the equipment and facilities in the emergency room are more adequate and modern than those in the physician's office.

8. Physicians frequently encourage their own patients to go to the emergency room for treatment by them of the patient's minor illness or injury.

9. The major reason appears to be the public's general acceptance and seeming approval of the idea that hospital facilities—and particularly emergency room facilities—should be available for all kinds of illnesses and injuries—the idea that the hospital emergency room should be a sort of community medical center or "neighborhood drop-in clinic."

PROBLEMS IN SOME AREAS

Regardless of the validity of any of these reasons for this tremendous increase in the number of cases coming into the emergency room, the fact remains that the overwhelming demand for medical services in the hospital emergency room has created critical problems in some areas, such as:

1. The need for enlarged emergency room quarters.

2. The need for adequate modern equipment and facilities.

3. The need for adequate staffing of competent personnel, professional and non-professional, to handle emergency cases.

4. The need to reconvert the "community medical center" or "neighborhood drop-in clinic" into a true emergency room for the care and treatment of true emergency patients. Such reconversion will involve both the education of the public to the proper function and use of the emergency room, and the cooperative effort of hospital and medical personnel in the reference of non-emergency cases to the private practitioner, medical clinic or the out-patient department. This will also involve a complete separation of the emergency room department from the out-patient department.

All of these needs must be met. The public rightfully demands (and is entitled to) the rendition of high-quality medical care and the maintenance of emergency rooms which have the facilities needed for the prompt rendition of medical services by a staff of licensed physicians. Assuredly, the medical profession wants to see these rightful demands met. In meeting these demands, it is important to keep in mind two things: (1) the separate and distinct functions of the hospital and the medical practitioner, and (2) the fact that the proper and efficient operation of emergency room service requires close cooperation between the hospital and the medical profession in the performance of their separate functions. Each needs the other. The hospital cannot lawfully practice medicine. The medical profession cannot effectively practice medicine without the use of hospital facilities and non-professional personnel of the hospital.

SEPARATE FUNCTIONS AND RESPONSIBILITIES

The furnishing of the physical equipment and facilities of the emergency room, the furnishing of necessary non-professional personnel, and the general administration and operation of the emergency room, are the proper function and responsibility of the hospital.

On the other hand, the rendition of professional services in the emergency room is the exclusive right and responsibility of the medical profession; such professional services may legally be rendered only by duly qualified physicians directly or by hospital personnel under the direct supervision and control of the physicians. The hospital has no legal right to direct, control or supervise the rendition of any services which are of a professional character, regardless of whether such services are rendered by the hospital's non-professional employees, or by its salaried physicians, or by physicians under contract with the hospital; and any attempt by the hospital to direct, control or supervise such services would constitute, in my judgment, the unlawful practice of medicine. Furthermore, even though the hospital should not attempt to direct, control or supervise the rendition of professional services in the emergency room, the hospital would nevertheless be engaged in the unlawful practice of medicine if it receives the whole or any part of the fee charged for such professional services, or if the hospital otherwise derives any profit, financial gain or benefit from the rendition of such services.[1]

PRINCIPLES OF MEDICAL ETHICS

It should also be mentioned here that a physician who permits fee-splitting with the hospital, or who renders professional services (in the emergency room or elsewhere in the hospital for that matter) under an arrangement whereby the hospital derives some profit, financial gain or benefit, is guilty of a violation of the *Principles of Medical Ethics.*

In this connection, I call attention to Sections 6 and 7 of the *Principles of Medical Ethics* of the American Medical Association.

Section 6 reads:

"A physician should not dispose of his services under terms or conditions which tend to interfere with or impair the free and complete exercise of his medical judgment and skill or tend to cause a deterioration of the quality of medical care."

Section 7 reads:

"In the practice of medicine a physician should limit the source of his professional income to medical services actually rendered by him, or under

his supervision, to his patients. His fee should be commensurate with the services rendered and the patient's ability to pay. He should neither pay nor receive a commission for referral of patients. Drugs, remedies or appliances may be dispensed or supplied by the physician provided it is in the best interests of the patient."

These sections have been interpreted by the Judicial Council of the AMA as forbidding the following:

1. Any interference by a hospital with the free and complete exercise of the physician's medical judgment or skill through any direction, control or supervision by a hospital over the physician's performance of medical services.
2. The receipt and retention by the hospital of the whole or any part of a fee paid for professional services rendered by a physician employed by the hospital on a salary basis or other contract basis, regardless of whether such payment is made to the physician and a part thereof delivered over to the hospital or whether the fee is paid to the hospital and the whole or a part thereof is retained by the hospital.

EXPLICIT UNDERSTANDING

How, then—it may be asked—can the demands of the medical public for adequate emergency room services be met without involving the hospital in the unlawful practice of medicine or involving the emergency room staff of physicians in a violation of the *Principles of Medical Ethics*? I submit that this can be accomplished by a clear, explicit understanding between the hospital and the emergency room physicians as to (1) the legal limitations on the functions and activities of the hospital, and (2) the ethical limitations that are imposed on all practicing physicians by the *Principles of Medical Ethics*, coupled with a willing obedience to these legal and ethical principles by the hospital and the emergency room physicians, respectively.

In this connection, it must be borne in mind that the unlawful practice of medicine by a hospital is usually accomplished through or by means of the unethical practice of medicine by the physician. It thus becomes readily apparent that if every physician will carefully refrain from entering into any arrangement with a hospital (1) which involves fee-splitting, or (2) which involves the obtaining by the hospital of some profit or other financial gain or benefit from the professional services of the physician, or (3) which subjects the physician to any direction, control or supervision by the hospital over his professional judgment—the practice of medicine by hospitals will be greatly reduced and, perhaps, eventually eliminated.

CONTRACTUAL ARRANGEMENTS

There are several forms of contractual arrangements for the staffing and operation of the emergency room which, if properly implemented and conscientiously adhered to, will not involve the hospital in the practice of medicine or expose the physician to a charge of violating the *Principles of Medical Ethics*. These may be summarized as follows:

Arrangement #1. This would provide for the rendition of services by use of bona fide interns and residents in AMA-Approved Emergency Room Training Programs, under the active guidance of the medical staffs. Under this plan, no charge would be made by the hospital for the professional services so rendered and no part of any fee that might be collected from the patient would be shared by the hospital.

Arrangement #2. Services would be rendered on a fee-for-service basis by several practicing physicians who would be approved by the medical staff with a minimum monthly compensation guaranteed by the hospital. As in Arrangement #1, no charge would be made, or fee collected or shared, by the hospital for any such professional services.

Arrangement #3. Services would be rendered by members of the medical staff either on a voluntary or mandatory assignment, and on a fee-for-service or gratuitous basis with billing, if any, direct by the physician for such professional services. Again, no charge would be made by the hospital for such services and there would be no splitting of fees as between the physician and hospital.

Arrangement #4. This provides for services to be rendered by several practicing physicians (employed by a medical partnership or a medical corporation) who would be approved by the medical staff. The billing and remuneration for such professional services would be the prerogative and responsibility of the medical partnership or corporation and the employed physicians. In no event would any charge be made, or fee collected or shared, by the hospital for any such professional services.

There is another form of contractual arrangement which might pass muster but which I think less desirable than the four forms of arrangements I have just mentioned. We shall call this "Arrangement #5." Under this Arrangement, services would be performed by one or more licensed physicians approved by the medical staff and employed by the hospital on a salary basis. Such services would be rendered without any charge being made by the hospital, or any fee collected or shared by the hospital, for such professional services. Further, there would not be included in the hospital's bill for hospital services any charge whatever for the professional services of the salaried physician. I consider this Arrangement #5 much less desirable because I think it is too much to expect that the hospital would pay a fair and reasonable salary without expecting and obtaining some financial benefit—by way of fee-splitting or otherwise—from the professional services of the salaried physician.

CONSIDERATION OF NEEDS

Each of these five arrangements or methods seems unobjectionable from the standpoint of legality and medical ethics. The selection of any particular method of staffing the emergency room will depend, I think, on the particular needs of the community and the particular conditions under which a group of physicians is willing to undertake the responsibility of staffing. Obviously, that method should be selected which promises to do the best job in the community (a) in rendering high quality medical care to emergency patients, and (b) in preserving and promoting the best possible relation between the profession and the hospital, between physician and physician, and between the medical profession and the public. Other things being equal, that method should be selected which affords the least opportunity—the least temptation—to the hospital and physician to indulge in practices which are unlawful from the standpoint of the hospital or unethical from the standpoint of the physician.

While each one of these several contractual arrangements, if conscientiously adhered to by the hospital and the emergency room physician, should prove effective in preventing the encroachment of hospitals upon the practice of medicine, there are other important factors that must be given serious consideration in the development of a successful hospital emergency room plan. In the first place, it is of the utmost importance, I think, that the hospital emergency room program have the full approval and support of the private practitioners in the community.

MEDICAL SOCIETY RESPONSIBILITY

We all know that it is the responsibility of the medical profession to see to it that adequate, high quality medical care is rendered at all times, in all places, to all patients. Consequently, the local medical society has, or should have, a decided interest as well as a professional duty with respect to the details of any plan for the staffing and operation of a hospital emergency room. The local society owes a duty to the public as well as to the local profession to ascertain whether the emergency room program will be implemented in such fashion as to insure the rendition of high quality emergency care. At the same time, it has the right, and it also owes the duty to the practicing physicians in the community, to insist that the activities of the emergency room staff be confined, as a general rule, to the treatment of true emergency cases to the end that there may be preserved complete confidence, respect, and harmony as between the members of the emergency room staff and private practitioners.

EVALUATING AN EMERGENCY ROOM PLAN

It is my belief that any contract, arrangement or plan for the staffing and operation of a hospital emergency room should be carefully analyzed and evaluated by the local society before the plan is finalized and put into effect. Any such plan might well be tested and evaluated on the basis of the answers to the following questions:

1. Is the plan such as to give assurance of the rendition of high quality medical care in true emergency cases on a round-the-clock basis?
2. Will the responsibility, control and direction of professional services in the emergency room be kept exclusively in the hands of the medical profession?
3. Will the group of physicians staffing the emergency room have the respect and confidence of the local society and of the profession generally, both with respect to the competence of the group and with respect to their ethics and integrity?
4. Does the plan provide that the physicians staffing the emergency room will limit their services and activities to true emergency cases and will render emergency services to a patient only if the patient's own physician is unknown or is not immediately available?
5. Will the treatment by the emergency room group of an emergency case be limited to such initial treatment as the emergency case requires?
6. Will the emergency room staff, as a matter of course, refer each emergency patient to his own physician for necessary follow-up care?
7. Will each non-emergency patient be referred to his own physician without treatment by the emergency room group except perhaps for necessary first aid? If the patient has no family physician, will the patient be afforded freedom of choice of physician—freedom to choose either a member of the emergency room group or some other physician? Will the emergency room group be circumspect regarding this matter so as to maintain the confidence, respect and esteem of their confreres in private practice?
8. Will the plan have the approval and cooperation of the local medical society and the medical profession generally?

It is obvious, I think, that the ideal emergency room plan will provide affirmative answers to each of these questions.

INTEREST OF THE PUBLIC

In the final analysis, the best interests of the public will be served, the best interests of the hospital will be served, and the best interests of the medical profession will be served if the emergency room plan clearly delineates, in writing, the respective functions, rights, responsibilities and obligations of the hospital and the physician. Regardless of the particular method selected for the staffing and operation of the hospital emergency room, the contractual arrangement between the hospital and each emergency room physician should be such as

(a) will allow the physician to retain his professional integrity and independence;

(b) will leave unimpaired the physician's right to the free and complete exercise of his medical judgment;

(c) will recognize the physician's right to fix, collect and retain the entire amount of his fee for professional services rendered to patients in the emergency room—without any fee-splitting of any sort or the deriving by the hospital of any profit, financial gain or benefit, directly or indirectly, from the professional services rendered by the physician; and

(d) will preserve and promote the best of relations between the medical profession and the hospital, between the emergency room staff physicians and their confreres, and between the medical profession and the public.

EDITOR'S NOTE:

1. Society attorneys advise that the foregoing paragraph and those which follow it are consistent with the Wisconsin law and constitute an excellent summary of the law as well as of medical ethics on the question involved.

Those having a special interest in the fee splitting aspects of the question should refer to the *Guide to Interpretation of Chapter 484, Laws of Wisconsin, 1959*, approved by the Council of the State Medical Society of Wisconsin in November, 1960 and distributed to all members.

SERVICES TO PHYSICIANS AND THE PUBLIC

from the

PUBLIC INFORMATION DEPARTMENT OF THE STATE MEDICAL SOCIETY

The following services are provided to member physicians and the general public, under the direction of the Commission on Public Relations and Communications—a standing committee of the Council. For the most part they are designed to assist the physician in preparing for participation in health education events such as speeches to non-medical audiences, or to provide factual health information directly to the general public. Address requests, or have your patients write: Public Information Department, State Medical Society of Wisconsin, Box 1109, Madison, Wis. 53701.

LOAN PACKETS

Packets of reference materials are provided, on a loan basis, on such topics as Fluoridation, Establishing a Practice, Health Fads and Fallacies, Alcoholism, Health Careers, Emotional Aspects of Malignancy, and numerous others.

FILM SERVICE

An index of films, suitable for both medical and non-medical audiences, is maintained by the Society. Please be as specific as possible concerning the desired topic. Since the Society does not maintain a film library and all films must be ordered from another source, two weeks notice is desirable. Cost normally involves only return postage, however in some cases there is a rental or service charge to be paid by the recipient.

HEALTH CAREERS MATERIALS

Materials on careers in medicine are available as references for physicians participating in Career Days and leaflets are available in quantity for distribution to groups. Reference materials on careers ancillary to medicine, and sources of loans and scholarships are also available.

HEALTH EDUCATION LITERATURE

Single pamphlets are available on a wide range of topics for individuals seeking factual information on health.

MOUTH-TO-MOUTH BREATHING AND CLOSED CHEST CARDIAC MASSAGE

Films and a demonstration manikin are available for special programs on mouth-to-mouth breathing and closed chest cardiac massage. The latter topic is considered appropriate for physicians, nurses, policemen, firemen and rescue personnel, and requires supervision of a physician trained in the technique.

SPEAKERS SERVICE

While it is normally desirable to have a local physician fulfill speaking engagements in his community, speakers are available on the state level where a special topic or audience size makes it desirable.

Rehabilitation of the Epileptic in Wisconsin

JEAN P. DAVIS, M.D., Milwaukee, Wisconsin, and ADRIAN E. TOWNE, Madison, Wisconsin

VOCATIONAL REHABILITATION in Wisconsin has worked with the epileptic since the early 1930s. Success at first was negligible. Because seizure control was limited to those cases which would respond to phenobarbital, its sedative effect made employment difficult. Not until after 1938, when diphenylhydantoin sodium (Dilantin) provided the first nonsedative anticonvulsant, did it become feasible to think in terms of successful vocational rehabilitation of the epileptic. In 1942 the Rehabilitation Division undertook what was probably the nation's first study of vocational rehabilitation in epilepsy. Rehabilitation counselors felt that the controlled epileptic could contribute to wartime production, and the study showed that with proper placement the epileptic could make a definite contribution. Since World War II, vocational rehabilitation of the epileptic has been steadily increasing, to the extent that he now makes up about 5 per cent of all clients served.

In the mid-1950s, problems associated with epilepsy in Wisconsin came in for exhaustive study by the Rehabilitation Division. Findings of the survey constituted a widely circulated report in 1957. Analysis of the problem from the medical, educational, and employment aspects supported the thesis that the social problem in epilepsy today transcends the medical. Documented employer reluctance to hire the controlled epileptic stood out as the principal stumbling block in the return to normal life. This attitude was not confined to employers, the survey showed. In 1957 a number of Wisconsin public schools and colleges barred known epileptics.

Vocational rehabilitation services for the epileptic vary little from those provided other clients. Once eligibility is established, there must be medical and psychologic evaluations preparatory to establishment of a vocational objective. If something less than perfect seizure control has been achieved, Vocational Rehabilitation first refers the client to a specialist to work out the medical aspects of the problem. This may be at the University of Wisconsin Epilepsy Center in Madison, the Variety Club Epilepsy Center at Mt. Sinai Hospital in Milwaukee, or with other qualified specialists. In some cases severe emotional involvement may necessitate psychiatric consultation along with the seizure control efforts. Whenever possible, training will be undertaken concurrently with treatment. Training may range from instruction in basic work skills at a sheltered workshop to graduate study at the University. Our epileptic clients run the gamut of the IQ scale, so there can be no generalization as to one best vocational objective for them. We would steer all of them away from hazardous jobs.

In most cases the cost to epileptic clients for vocational rehabilitation will be negligible. No charge is made for counseling, guidance, and medical examinations. Tuition, books and training supplies are provided without cost. If financial need can be established on the basis of family income, the epileptic can also receive without cost the medical or psychiatric treatment needed to make him employable. Establishment of need is also necessary before we can pay transportation and maintenance costs during training or treatment. Most cases can establish need.

Eligibility for vocational rehabilitation services has been established by both state and federal statutes. It is based upon:

(1) The presence of a physical or mental handicap.
(2) The existence of a substantial handicap to employment.
(3) A reasonable expectation that through vocational rehabilitation services the handicapped person will again be able to work.
(4) The handicapped person must be of or near employable age.
(5) Residency in Wisconsin for one year is required, unless he was living in the state at the time of becoming handicapped.

The epileptic can refer himself for service to the Rehabilitation Division, but most will come on referral from educational institutions, hospitals, nurses, physicians, social workers, and related groups.

Surprisingly enough, comparatively few epileptics come to Vocational Rehabilitation on referral from physicians. This is unfortunate, because a closer relationship should exist between the medical profession and Vocational Rehabilitation, not just in the case of epilepsy but with all handicaps.

Removal of impairments is paramount in the rehabilitation process, whether by prosthetic devices, corrective surgery, speech therapy, or by other means. Such costs are underwritten by the Division

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Approved by the Division on Nervous and Mental Diseases of the State Medical Society's Commission on State Departments, Oct. 9, 1966.

Doctor Davis is a member of the Division and a member of the Advisory Committee on Epilepsy to the State Board of Health.

Mr. Towne is director of Vocational Rehabilitation, State of Wisconsin.

of Vocational Rehabilitation once financial need has been established. In epilepsy, Vocational Rehabilitation stands ready to meet the expenses of seizure control where financial hardship exists. This is particularly important for those with intractable seizures. When patients do not respond to standard treatment methods, the physician should contact Vocational Rehabilitation to determine his patient's eligibility for VR services. This could lead to a specialist's care at Madison, Milwaukee, or elsewhere, hopefully resulting in seizure control which otherwise would remain unattainable.

If a physician has already achieved seizure control, he should then refer his patient to the Division of Vocational Rehabilitation for job preparation. Removal of the medical barrier is only one step. As long as the employment barrier remains, the epileptic's rehabilitation has just begun. Vocational Rehabilitation is geared to this problem, providing without cost the counseling, evaluation, training, and job placement services so necessary in the restoration of the epileptic to a normal life.

Following is a listing of Vocational Rehabilitation offices:

District I:

District Office
117½ Monona Ave.
Madison
Telephone: 266-3655
R. R. VanDeventer,
District Supervisor

Local Office
State Office Bldg.
Mormon Coulee Road
La Crosse
Telephone: 784-0474
C. J. Haase,
Rehabilitation
Supervisor

Mendota State Hospital
301 Troy Drive
Madison
Telephone: 244-2411
P. W. Rasmussen,
Rehabilitation Counselor

District II:

District Office
819 North 6th Street
Milwaukee
Telephone: 224-4677
W. R. Newberry, Acting
District Supervisor

Milwaukee County
Hospital
9035 Watertown Plank
Road
Milwaukee
Telephone: 258-2040
K. F. Krumnow,
Rehabilitation Supervisor

District III:

District Office
100 North Jefferson St.
Green Bay
Telephone: 432-8691
L. J. Schultz
District Supervisor

Local Office
200 Franklin Street
Wausau
Telephone: 845-9261
R. C. Huser,
Rehabilitation Supervisor

District IV:

District Office
718 West Clairemont Ave.
Eau Claire
Telephone: 834-5051
L. E. Opheim,
District Supervisor

Local Office
917 Tower Avenue
Superior
Telephone: 392-8171
L. R. Forslund,
Rehabilitation Supervisor

District V:

District Office
312 Seventh Street
Racine
Telephone: 632-4477
Roger Siegworth,
District Supervisor

Local Office
217 Wisconsin
Waukesha
Telephone: 542-9414
E. C. Wilber,
Rehabilitation Supervisor

District VI:

District Office
20 Forest Avenue
Fond du Lac
Telephone: 921-5883
K. T. McClarnon,
District Supervisor

Local Office
424 Washington Ave.
Oshkosh
Telephone: 231-5220
J. A. Mather,
Rehabilitation Supervisor

Winnebago State Hospital
Winnebago
Sylvester Verbeten,
Rehabilitation Counselor

Wood County Project:

Court House
Wisconsin Rapids
Telephone: 424-1100
J. H. Roemer,
Project Supervisor

also office at
116 West Second Street
Marshfield
Telephone: 384-4310

INTERNATIONAL CERTIFICATES OF VACCINATION

Copies of the International Certificates of Vaccination, PHS-731 as revised September 1966, are now available. *This certificate form must be used beginning January 1, 1967* for all vaccinations performed in the United States for international travel. Smallpox, Cholera and Yellow Fever Vaccination Certificates already issued remain valid until the expiration date of the certificate. This revised edition includes changes in the smallpox and yellow fever vaccination certificates, as amended by the Eighteenth World Health Assembly in May 1965. *All certificates printed prior to September 1966 should be destroyed.*

The International Certificate of Vaccination or Revaccination against Smallpox requires the physician to indicate that either a freeze-dried or liquid vaccine, certified to fulfill the World Health Organization's recommended requirements for manufacture of the vaccine, was used. Also, the origin and batch number of the vaccine must be recorded.

The International Certificate of Vaccination or Revaccination against Yellow Fever was amended to extend the validity of the certificate from 6 to 10 years as of May 12, 1965. Yellow Fever Vaccination Certificates already issued are automatically extended to be valid for 10 years from the date of vaccination or revaccination.

A supply of the new certificates are on sale at the Superintendent of Documents, Government Printing Office, Washington, D. C. 20402, at 10¢ a copy or $5.00 per hundred.

When a Lawyer Asks You for a Report

By WINFIELD S. MILLER II, LL.B., Oradell, New Jersey

"THE PHYSICIAN UPON proper authorization should promptly furnish the attorney with a complete medical report and should realize that delays in providing medical information may prejudice the opportunity of the patient either to settle his claim or suit, delay the trial of a case or cause additional expense or loss of important testimony."

So declares the interprofessional code of the A.M.A. and the American Bar Association. They jointly adopted it back in 1958.[1] Yet the problems of belated or inadequate medical reports that the code sought to end are still with us. Overlong time lags between the occurrence of accidents and the presentation of claims are still causing the loss of witnesses and evidence; incomplete and ambiguous medical reports are still doing disservice to patients, attorneys and justice.

It's not as if doctors were being asked to prepare reports for nothing. The interprofessional code spells out the fact that the physician "is entitled to reasonable compensation for time spent in . . . preparation of medical reports." Your patient knows you're busy and so does his attorney. But they need your help in personal injury litigation and are quite willing to pay for it. It's up to you to decide what you think is a fair fee in a given case, figuring it on the basis of time spent. However, it's a rare attorney who won't pay more for a prompt and proper report than for a slow and inadequate one.

Some attorneys point out that the inadequate jobs are usually the slowest to reach them. I suspect that one reason some doctors dawdle is that they're uncertain of how to compose a proper report. They're unsure of what to include and what to leave out. So it may be helpful to give a rundown on what the report should contain. Judging from my own knowledge and the experience of medicolegal colleagues, I'd say that the report designed to earn an acceptable fee should be handled along these lines:

1. The report should avoid going into detail about the accident. Naturally, the doctor should, if possible, give the date, time and place of the accident. He also should tell who gave the first aid, if any, and just what it was.

Unless the doctor actually witnessed the accident, however, there's a good chance he'll be wrong on some detail if he goes into a report of the accident itself. Any error can cast doubt on his competence and accuracy and may even cause the plaintiff to lose his case unjustly. At the least, a report on the accident can result in wasted time for all concerned in setting the record straight.

For example, one surgeon turned in a long report that looked fine—until the attorney spotted a glaring mistake. The doctor had stated that the lumber company employe in the case had been injured in a highway auto crash. In reality, the mishap had occurred in a storage shed in the lumberyard when the man was run over by a loading machine. Under the company's insurance policy, he was entitled to compensation. But because the policy excluded automobile injuries, the insurer would have denied liability if the doctor's error had been allowed to stand. Fortunately, it wasn't, but the surgeon and the attorney wasted valuable time fixing it.

Says Dr. Don Harper Mills, an M.D. and LL.B. who is associate clinical professor of forensic medicine and pathology at the University of Southern California: "If the doctor is the treating physician, his recitation of historical facts should be limited to those that were necessary for his diagnosis and treatment. Any facts of which he hasn't first-hand knowledge should always be prefaced by attributions such as 'the patient states' or 'the emergency room records disclose.'"

2. The report should give the date the doctor first examined the patient and should explain any delay between accident and examination. While on vacation in Vermont, a woman was knocked down by a bicyclist. Though bruised and shaken up, she seemed to have no serious injury. The next morning she awoke in much pain. Her husband urged her to see a local doctor, but she insisted on being examined by her own physician. They returned home to Rhode Island and found that their family doctor was away for the weekend. The woman's pain had subsided, so she decided to wait. When she finally saw her doctor, he decided to send her to the hospital, where she spent the next two weeks in traction. But he couldn't honestly say that the delay in getting treatment had worsened her condition.

In his medical report to the attorney some weeks later, the doctor stated, "I first examined the patient for this condition in my office on July 14, 1964."

Mr. Miller is Associate Editor, MEDICAL ECONOMICS.

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The accident had occurred on July 9. The report said nothing about the delay. But the insurance company's representative did. He successfully implied that the patient would have had far less pain and suffering if she'd been treated immediately. Her compensation was accordingly less than it should have been.

Most medicolegal experts hold that an adequate report should—if medically practical—state the circumstances of any such delay and the doctor's opinion as to how it may have affected the patient's condition. But some experts feel there should be no more than a well-attributed mention of what caused the delay—if that. "I don't usually advise doctors to go into explanations of why delays occurred," says Dr. Mills. "This is an embellishment that could lead to trouble. Let the attorney and his client fill in any such defect in the report, if necessary."

3. The report should give a complete description of the patient's symptoms and complaints when first examined. An injured patient's appearance may seem unimportant medically, but it could well affect his legal chances. If he was bleeding from lacerations, obviously this should be stated in the report. And, less obviously, if he was pale and cold, this should be mentioned. So should his complaints. If he said he felt faint and had back pain and a throbbing headache, this ought to go into the report.

Says attorney Mead Bailey of Sioux Falls, S. D.: "To make certain no complaints are overlooked, the doctor should carefully interrogate the patient. Naturally, the doctor has a good idea of what the complaints would be for any type of injury. Evidence that a patient did *not* have certain complaints can help to pinpoint and prove what the nature of injury actually was."

4. The report should describe all treatment and medication given. Not long ago, a doctor prescribed medication to relieve muscle spasm for several days after a woman's accident. When the pain continued after the pills were used up, he suggested she take aspirin daily. She did so for some weeks. Yet the doctor mentioned only the prescription pills in his report. Why should he also have included the aspirin? Because any treatment or medication, no matter how routine it may be to the doctor, could help determine the amount of the client's financial recovery for pain and suffering.

5. The report should mention continuing defects, disabilities or scarring. It should, for example, describe the size, location and extent of a scar caused by the accident. If the doctor has recommended plastic surgery, he should certainly say so. If he fails to report it, the attorney may not be able to include the cost of future surgery in the settlement figure.

If the physician thinks the patient is still suffering as a result of the accident, he should estimate in the report how long this will continue. He should estimate the cost of any medical care he thinks the patient may have to undergo.

Estimating how long the patient may continue to suffer the effects of the accident is especially important if there's a possibility of permanent injury. This can be vital in a case involving a minor. Once the court has approved a proposed settlement, no further damages may be sought for the minor, even though his injuries may prove to be more serious than at first reported. Of course, if it's too early for a prognosis, the doctor shouldn't guess. It's better to report that he's withholding his prognosis, pending future examinations.

So much for the elements that a medical report ought to contain. Now, how about its length? That depends entirely on the medical situation and how much there is to cover. The attorney needs a *complete* report, and the doctor may greatly increase the chances of an out-of-court settlement by doing a thorough job. An incomplete, vague report can lead to argument—and often to a trial. Thus, the time a physician spends on doing a finished job may save him a trip to court.

The doctor shouldn't hesitate to ask the plaintiff's attorney for help, if he needs it. And, if the doctor is pressed for time, he should request that the attorney come to his office for any necessary conferences.

Finally, the report should be submitted in triplicate and with a statement of the doctor's total fee. The amount, as I've suggested, should reflect how much time you and your aides have spent in preparing it and should include charges for any conferences required. Writing in MEDICAL ECONOMICS not long ago, Dr. Edgar Rosen, an Oakland, Calif., internist with a special interest in medical reports, made this comment: "One fee can't be assigned to all kinds of medical reports, any more than we can have one standard fee for all kinds of operations."

. . .

In any event, most doctors would agree with Jack H. Olender, a Washington, D. C., attorney specializing in personal injury cases, when he says, "It seems to me that a doctor's duty to try to heal and rehabilitate his injured patient includes the preparation, when requested, of a clear and full report that will be helpful to the patient in obtaining whatever compensation he's entitled to."

EDITOR'S NOTE:

1. Also consistent with interprofessional code between the State Medical Society of Wisconsin and the Wisconsin Bar Association adopted August 1955.

* * *

SMALLPOX IS A disfiguring as well as a highly communicable disease. It is prevalent in many areas of South America, Asia, and smallpox cases are still being reported in parts of Europe. The State Board of Health urges people in Wisconsin to be vaccinated against smallpox because of the influx of foreign students, international shipping by way of the St. Lawrence Seaway, and visitors from overseas.

Are You Risking an Abandonment Charge?

The doctor shortage and the mechanization of medicine are increasing the risks, says this attorney, who describes the dangers of telephone diagnosis and other traps

By NEIL L. CHAYET, Esq., Boston, Massachusetts

IT'S FAIRLY COMMON practice for a busy doctor to postpone seeing a patient. But it can also be a dangerous practice. For if the doctor's patient load is so heavy that he must neglect some of his patients—and a patient's condition worsens as a result of that neglect—he may be open to a charge of abandonment.

Abandonment suits still aren't everyday affairs, but they show signs of increasing. The probable reasons aren't far to seek: (1) the shortage of doctors, tempting physicians to take on more patients than they can handle; (2) "the mechanization of medicine"—meaning the increasingly impersonal doctor-patient relationship resulting from specialization and the related movement of medicine toward team care in highly mechanized hospitals.

On the whole, patients haven't realized how much the nature of medical practice has changed. They still expect their doctor to come running at the ring of a telephone. If he won't and hasn't warned them that he won't make house calls they may well feel abandoned—and make their next phone call to a lawyer.

Just what is the medicolegal meaning of abandonment? Laws vary from state to state and interpretations from court to court, but in general it means a physician's termination of a doctor-patient relationship without the patient's consent and without giving him adequate notice and opportunity to find another physician. Such a relationship is established when a doctor accepts a person as a patient. But in law, even simple-sounding words usually aren't as simple as they sound. Many abandonment cases have hinged on whether the doctor had indeed "accepted" the person as a patient and if so under what conditions or limitations. For some legal interpretations of the terms "doctor-patient relationship" and "accept" and "terminate," let's take a look at some specific situations and cases:

When a stranger phones you for emergency treatment. "I've got these terrible stomach pains," he tells you. "Could you come right away?" No statute compels you to accept any would-be patient, and you're on safe legal ground if you refer him to another physician or to the nearest emergency room. But there's one condition: Don't attempt to diagnose his illness or recommend treatment. If you do, a court may rule that you thereby accepted the stranger as a patient and so assumed the responsibility for his treatment.

New York had a case in point not long ago. A man awoke with severe chest pains and walked to the emergency room of a hospital three blocks away. He mentioned that he was a member of a group health plan. The nurse told him the hospital had no connection with the plan and put him in touch with one of the plan's doctors. Over the phone, the man described his pains and medical history to the doctor, who allegedly told him to return home and see his regular physician in the morning. The sick man obediently went home—and died. A suit against the doctor and the hospital was dismissed, but an appellate court ordered a new trial. Had the suit not been dismissed, the court ruled, a jury could have concluded that the doctor "undertook to diagnose the ailments of the deceased" and that the jurors thereupon "could have decided whether he had abandoned the patient." Eventually both doctor and hospital agreed to a settlement.

When a former patient demands to see you immediately. Is there a doctor-patient relationship when a patient whom you treated for a broken leg five years ago and haven't seen since asks to see you at once? The essential question here is whether the original relationship was terminated. This in turn depends on the nature of the illness. In the case of a broken leg, a court would probably hold that termination had occurred after complete recovery or, more specifically, one year after the doctor's final checkup and the payment of the bill. Thus you would have as much right to refuse to see this former patient as you would have to turn away a stranger.

When you want to terminate a relationship. In the case of a disease such as cancer, where the cure may not be final, either doctor or patient would have to end the relationship formally, usually with a letter of termination. Such a letter from a doctor should always advise the patient whether he needs further treatment and allow him enough time to arrange for it. Not long ago, the Florida Su-

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preme Court upheld a $65,000 verdict against a doctor who had discharged a patient suffering from a cancer that later enveloped his entire lower lip and chin. The doctor had neither recommended nor arranged for further treatment.

Formal termination isn't necessary with most of your patients; as in the case of the broken leg, termination is implied by the conclusion of the illness. Be sure, however, to terminate your relationship *officially* with patients who won't pay their bills. When a patient doesn't pay, it usually means he doesn't have the money or is dissatisfied with you. Either situation could motivate a suit. It has been argued that a letter of termination in itself may precipitate a law suit. It may—but it's riskier to do nothing and thereby invite an eventual charge of abandonment.

When a regular patient demands priority. Suppose a patient comes into your office and asks to see you at once, ahead of others waiting for you. You're on safe legal ground if you refuse to treat him ahead of other patients—unless he's come to consult you because of a genuine emergency. It's a physician's right to regulate his practice as he sees fit.

The question of what constitutes an emergency is also left to the doctor's medical judgment. But your judgment may have to survive a court test. Recently a Tennessee doctor and his nurse had to pay $25,000 for failing to respond in an emergency, even though it wasn't proved that their failure caused the patient's death. The mother of a 22-month-old boy, who was being treated for a tonsil and throat infection, had brought him to the doctor's office when his condition worsened. The nurse notified the doctor, who was at lunch, and then went to lunch herself. While both were out of the office, the child died after profuse vomiting.

When the mother sued both doctor and nurse for abandonment, the doctor and his expert witnesses testified that the child had died of a sudden viral infection. An appeals court affirmed that the jury could disregard such testimony and find that the child might have died of aspiration of its own vomit. In such a case, the court held, the child might not have died if he had received immediate treatment from either doctor or nurse. As this case makes clear, a doctor's momentary neglect may be enough to constitute abandonment.

When absence makes you unavailable to the patient. The key concept here is not the fact of leaving the patient, but leaving him without providing for his care in your absence. A few years ago, the Supreme Court of Oregon affirmed a judgment against a doctor who had neglected to make such provision. The suit was brought against him by a woman whom he had treated for a broken arm. Up to the day the doctor left for a vacation in Mexico, the woman complained that the cast on her arm was too tight, but he thought it unnecessary to split the cast or remove it. Nor did he entrust her to another doctor in his absence. When he returned and removed the cast, plaster and gauze were found imbedded in the flesh inside the elbow joint, according to one woman's testimony. Permanently crippled, the patient was awarded damages of $17,500.

The doctor planning a vacation or other trip must give his ailing patients enough advance notice of his impending absence to let them arrange for other medical help. How much notice depends on the illness. Two days would probably be enough for a patient with a broken arm, while 30 days might be in order for a patient requiring specialized treatment. Advance notice was at issue recently in Maine, where a doctor was granted a new trial after a jury verdict against him. Although the doctor had arranged for a competent substitute, he had failed to tell one of his pregnant patients that he was going on a two-day fishing trip.

During his absence, the woman's baby was delivered by the substitute. Later the woman sued her doctor charging that (1) she had suffered needlessly because the substitute failed to administer the anesthetic she wanted and (2) she had been denied the choice of another physician because her doctor hadn't warned her that he would be unavailable. The state Supreme Court took away her jury award on the ground that she had failed to prove she would have suffered less if her own doctor had been present. However the court confirmed the right of such a patient to receive plenty of advance notice concerning the need for a possible substitute obstetrician.

When a substitute physician errs. Are you responsible for your substitute's errors or derelections? Only if your patient can prove that you failed to exercise "due care" in choosing the substitute. A substitute may also be held liable for abandonment. That happened to a doctor who agreed with the surgeon, reversing a lower court decision and ordering a new trial. The suit was finally settled out of court.

The cases mentioned so far show patients seeking judgments for physical harm. But they may also try to collect damages for mental anguish. Unless accompanied by physical injury, however, mental anguish (as distinguished from mental illness) isn't usually actionable. Some courts, however, have ruled otherwise.[1]

In one such instance, a man was "abandoned" while receiving X-ray therapy for a cancerous growth on his cheek. He had been placed on a table with sandbags on both sides of his head and the X-ray machine trained on his cheek. Then the doctor and technician apparently forgot about him—after also neglecting to tell him that the machine would shut itself off automatically. The man lay there for three and a half hours, afraid to move, afraid not to move. Finally he fell off the table. He wasn't hurt physically, but the court allowed him to recover for his hours of mental anguish.

The cases cited show that a potential for a charge of abandonment exists in many common

situations. Happily, that potential is rarely realized. The physician can protect himself further with these four basic safeguards:

1. If you must turn away a patient, do so on medical grounds. It's acceptable to refuse a patient immediate attention if you feel others have more urgent need of your services. It's not acceptable to neglect him merely because you have too many patients.

2. When you accept a patient, state plainly whatever limitations you intend to put upon your services.

3. If you want to drop a patient or if a patient is dissatisfied and abandons *you*, be sure to send him a letter of termination. Keep all such correspondence as part of your records.[2]

4. Whenever you're going to be unavailable, notify patients who are acutely ill, pregnant, convalescing, or suffering from chronic disorders. Give those patients the name, address and phone number of a substitute physician.[3]

EDITOR'S NOTES:

1. After earlier hesitating about compensating for emotional harm suffered without attendant physical injury, the Wisconsin Supreme Court again considered this question in 1963. It held in *Alsteen v. Gehl*, 21 Wis. (2d) 349, at page 358 that the correct statement of the standard for legal liability is as follows:

> "One who by extreme and outrageous conduct intentionally causes severe emotional distress to another is subject to liability for such emotional distress and for bodily harm resulting from it."

2. The Society attorneys advise that after a physician gives notice that he wishes to withdraw from a case he should remain and perform necessary services until a successor physician acceptable to the patient takes over. Otherwise the first physician runs the legal risk of an abandonment charge, even though he gave written notice of his intention to withdraw.

3. An additional source of potential legal liability is the premature discharge of a patient. The legal principle has been well phrased as follows in a recent text:

> "Premature discharge of the patient may also result in a charge of abandonment if it turns out that the patient required further care under the standards of good medical practice."

Quoted from *Doctor and Patient and the Law*, Stetler and Moritz, The C. V. Mosby Company, 1962, p. 324.

THE CHARITABLE, EDUCATIONAL AND SCIENTIFIC FOUNDATION was founded in 1954 to permit physicians and friends of medicine an opportunity to sponsor projects affecting the health of Wisconsin citizens.

Among the many projects which are supported by this method is the Medical Student Loan Fund. Since the integration of the loan fund into the Foundation in 1955, the student loan aspects of the program have grown.

Every practicing physician recognizes the unquestionable need for timely aid to the kin of his profession who face unusual financial hardship. Personal hardship strikes at physicians and their families as well as others. Through the Foundation there is an opportunity for professional persons to assist their colleagues who suffer adversity.

The Scientific medicine activities of the Foundation include circuit teaching programs, speakers service for county medical societies, and the support of research in many fields in cooperation with other agencies.

The Foundation has not neglected the value of learning from the past and the Museum of Medical Progress and Stovall Hall of Health, reconstruction of the Fort Crawford Hospital in Prairie du Chien, have made many visitors aware of the role that medicine has and is playing in their lives.

The voluntary contributions recommended by the House of Delegates is being supplemented by many physicians and others who find in the Foundation an opportunity for special gifts. Gifts may take a number of forms such as cash, life insurance, securities, books, old medical instruments, stamp and coin collections, works of art and other artifacts. Some physicians are making the Foundation a beneficiary in their wills. Gifts may be unrestricted, permitting the Trustees to use the funds for any purpose for which the Foundation was created. They may also be restricted or earmarked for specific purposes of interest to the donor. In any event, all contributions to the Foundation are deductible for income tax purposes.

The Expert Witness

By BENJAMIN J. CANTOR, B.E.E., LL.B.

Beyond the basic qualifications of knowledge and experience necessary to be an expert in his field, an expert witness must also have the ability to communicate clearly and objectively his skilled interpretation of technical evidence. Mr. Cantor suggests thirty rules, ranging from manners to mannerisms, that will aid the expert witness in doing so, and thereby aid the judge and the jury in reaching a fair and proper conclusion from the testimony.

AN EXPERT WITNESS is one who has acquired by study, practice and extensive experience a special skill and superior knowledge in the art and science of a particular field about which persons who have no special training are incapable of forming an accurate opinion or of deducing correct conclusions. Whether a witness is qualified as an expert is a preliminary question of fact for the trial court to determine. This decision will not generally be overturned unless it can be shown that there was an abuse of discretion on the part of the presiding judge.

The expert witness differs from the ordinary witness in that the former can state his opinions or conclusions based on ultimate fact, whereas the latter can testify only to things that he saw, heard, tasted, smelled or felt. The weight that a jury will give to the testimony of an expert witness depends upon the extent of his learning, skill, experience and the reasons he gives for his opinions and conclusions.

The following factors are important in spelling out an expert witness's qualifications: education, experience, articles published, lectures delivered, membership in professional societies and organizations, awards and recognition as an expert by others in the same field. Because the expert witness' opinion often concerns one of the important elements of the case, *e.g.*, damages or liability, it is very important that he be well qualified and of high moral character and integrity. It must be remembered that the credence given by the court and the jury to the testimony of an expert witness depends principally on his qualifications, his ability to withstand severe cross-examination and his capability in expressing himself so that the judge and jury will understand his testimony.

Before an expert is put on the witness stand, the attorney should have a conference with him to determine his qualifications and also to seek his advice on the framing of questions. The attorney and the expert witness must have a meeting of the minds as to their objectives. In order to be most effective, the expertness of the witness and the legal astuteness of the lawyer should be aimed at the same objective.

As a witness, the expert should speak up so that the jury, judge, stenographer, opposing counsel and all other parties in the case can hear him. His testimony and explanations should be clear enough so that all of the jurors can understand and grasp them. Technical terms should be defined and put into simple language for effectiveness. In testifying from an exhibit, the witness should refer to the exhibit number or some other identification. When indicating or pointing to an object in the exhibit, he should describe what he is referring to so that the court stenographer can make an accurate and complete record of his testimony, which becomes very important when the transcript of the testimony is used in a hearing on a motion for a new trial or an appeal to a higher tribunal.

Enough time should be taken in answering questions so that the witness can gather his thoughts and give an accurate and brief answer. (It's like the fellow who apologized for writing a long letter and said that if he had had time it would have been shorter.) If the questions are answered quickly on direct examination, and then there is a tendency to slow up on cross-examination, the jury will notice this and feel that the witness is hedging or is in trouble. If the witness is asked to give an opinion and he feels that he hasn't enough facts or enough time to form an intelligent expert opinion, then he should so inform the court. A jury is impressed with such frankness on the part of a witness. The expert, not expected to rely entirely on his memory, should always have adequate notes in his possession when called as a witness so that he can testify as to all of the details. He should keep in mind that his role is to aid the court and the jury in understanding the technical evidence so that they can make a proper evaluation of the facts.

Some other suggestions which can be offered as an aid to being a good witness are:

1. Walk to the witness stand with even steps.
2. When taking the oath, hold your right arm up high with fingers straight and look at the officer administering the oath.

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Mr. Cantor is a professional photographer specializing in legal photograyhy. An author and lecturer on the role of photographs in civil litigation, he is a photographic arbitrator for the American Arbitration Association and a qualified legal-forensic photographer of the Professional Photographers of America.

3. When the officer finishes the oath, ". . . so help you God", you say "I do" in a loud voice so that all in the courtroom can hear. Do not act timid.

4. Think before you speak.

5. When one of the lawyers calls "Objection" or if the court interrupts, stop your answer immediately and wait until the court gives its ruling.

6. Be fair and frank. Don't be too anxious to please or too eager to fight.

7. If you make a mistake, or a slight contradiction, admit it and correct it. Don't tie yourself in knots trying to cover up some slip of speech or memory.

8. Keep your temper. Don't let anyone rile you into arguments over trivial points or even important ones. Be firm, but flexible.

9. If you can't answer "yes" or "no", say so. Modify your reply by "under certain circumstances . . .".

10. If you don't know or can't remember, say so. Those are legitimate answers to the most illegitimate questions.

11. Avoid mannerisms of speech. The habit of prefacing your replies with something like "I can truthfully say . . ." may cast unwarranted doubts on your whole testimony.

12. Don't get caught by snares like this: "Did you ever discuss this with anyone?" Of course you did, and if asked, name the people—the lawyer, the parties to the suit, etc.

13. If the lawyer asks you, "Are you as positive about this as the rest of your testimony?", STOP! Are you?

14. "Do you want this jury to understand . . . ?" Listen closely to that one. If you don't want the jury to understand it that way, make clear what you do want them to understand.

15. Never try to be a "smart" witness. If a lawyer is obviously giving you a chance for a wisecrack, avoid it like the plague. It's just the anesthetic before the knife—putting you in the "now-this-won't-hurt-a-bit" mood.

16. If the opposing attorney interrupts you before you have a chance to complete your answer, you should indicate this to the presiding judge.

17. Don't volunteer any information.

18. Express yourself well, using simple technical language that the jury, judge and attorneys can understand.

19. Be brief. Just answer the question and stop.

20. During the recess you should not carry on any conversation with other witnesses or parties to the controversy. You should stand aloof from everyone except the attorney who retains you to testify.

21. Don't chew gum.

22. Don't memorize any of your testimony.

23. Never nod your head to indicate "yes" or "no".

24. Speak up so that the judge, jury, counsel, stenographer and others can hear you.

25. Wait until the entire question is asked before answering.

26. On cross-examination, don't look at your attorney.

27. Keep your hands away from your mouth or face.

28. When addressing the court, use "Your Honor"; when addressing the attorneys, use their names.

29. At the conclusion of your testimony, ask if you may be excused; then leave the courtroom immediately.

30. Last, remember that the witness stand is not a comfortable place for one who is not telling "the truth, the whole truth and nothing but the truth".

An expert is entitled to a witness fee, the amount of which is subject to an arrangement between him and the attorney who calls him to testify. It is good practice to arrange for such a fee prior to testifying. If the expert is called on only to testify to facts of which he already has knowledge, he may be subpoenaed as a witness and paid the statutory fee, plus an allowance for travel. In this case he may refuse to give any "expert" opinion or testimony unless he is adequately compensated. An expert who is subpoenaed may not ordinarily be as cooperative and will not put as much effort into his testimony as one who has willingly agreed to appear as an expert witness. Thus, as a practical matter, the expert should be retained at a reasonable fee. If an expert must prepare himself before testifying by making certain tests or doing research, he is entitled to reasonable fees for that work. When an expert is called as a witness for the sole purpose of "proving" or verifying certain material, he is generally given a reasonable fee for his time.

It is wise, when called as a witness, to ask to be put "on call" so that there won't be time lost "hanging around" the courthouse. In any event, the witness shouldn't expect to be out of court in a hurry.

Some lawyers representing plaintiffs, especially in tort cases, will ask an expert to testify on a "contingent fee" basis—he won't be paid a witness fee if the plaintiff loses, but in the event that the plaintiff prevails, the expert will be paid. This puts the witness in the same position as the attorney who has a stake in the outcome of the case, and thus the witness gives up his proper role as a disinterested expert witness. Having a pecuniary interest in the case, the expert becomes an "interested" and biased party, and therefore his testimony will carry much less weight. It should be kept in mind that such a contingent fee arrangement is fundamentally against public policy and, therefore, invalid and unenforceable. The expert witness should be altogether objective and nonpartisan in presenting his opinions. He should keep in mind that he is being retained by the lawyer or party to the action and is not in their employ. He is an independent professional man.

The Abused Child Law

HOW IT AFFECTS YOU

Prepared by the Interprofessional Citizen's Committee on Planning for the Abused Child, a special committee of the Division for Children and Youth, Wisconsin State Board of Public Welfare. Dr. Kenneth J. Winters of Wauwatosa is the State Medical Society representative serving on this committee. This article has been printed in pamphlet form and is available from the Division.

PARENTS AND OTHERS who abuse children placed in their charge to the point of inflicting severe damage can be found at all economic, educational and social levels.

The cumulative effect of repeated beatings or other forms of severe abuse, which may include physical crippling, brain damage or even death, must be prevented. The 1965 legislature strengthened old legislation making reporting of suspected cases of child abuse mandatory, and extending the ranks of those required to report, from physicians and surgeons only, to include nurses, social workers and school administrators.*

This will assure that protection will be extended to the children and that perpetrators of abuse will be identified and will receive rehabilitative help.

While responsible professional people engaged in caring for children have not needed this law to prod them into taking protective action, this legislation is an important step in enlarging our effort to stop further abuses.

This pamphlet explains the law, the action that must be taken by people who are charged with responsibility by the law, and follow-up services that are to be provided to the child and his family.

THE LAW

On Nov. 10, 1965, the newly created Section 48.981 of Wisconsin Statutes went into effect. It added nurses, social workers and school administrators to those who are required to report cases of child abuse and spelled out how reports should be made:

48.981 REPORTS ON ABUSED OR INJURED CHILDREN. (1) A physician or surgeon being of the opinion as specified in s. 885.21 (1) (f), or a nurse, social worker or school administrator having reasonable cause to believe that a child brought to him or coming before him has had physical injury or other abuse inflicted upon him by another, other than by accidental means, shall orally report the same and the facts and circumstances forming the opinion. The report shall be made immediately by telephone or otherwise, and followed by a report in writing to a county child welfare agency specified in s. 48.56 (1) or the sheriff of the county. The recipient of the report shall notify the other receiver of reports within 48 hours. When the recipient of the report is the sheriff of the county, he shall make an investigation consistent with the facts and circumstances described in the report and take whatever emergency action is necessary for the protection of the child.

If the sheriff determines that legal action is necessary he shall refer the case to the district attorney for criminal prosecution. The county child welfare agency specified in s. 48.56 (1) shall investigate each report and act in accordance with its powers and duties as set forth in s. 48.57.

(2) Anyone, in good faith, participating in the making of a report pursuant to this section or participating in a judicial proceeding resulting therefrom shall in so doing be immune from any criminal liability, that might otherwise be incurred or imposed.†

(3) Anyone knowingly and wilfully violating this section by failing to file a report as required, may be fined not more than $100 or imprisoned not more than 6 months or both.

YOUR RESPONSIBILITY

Physicians, surgeons, nurses, social workers and school administrators may make their initial reports in any expeditious manner to either the county welfare department or the county sheriff. However, their follow-up reports must be in writing.

There are no legal requirements for the form of the written report. It may be a letter stating salient

* It is anticipated that the 1967 legislature will amend present legislation to expand the classes of mandatory reporting, including dentists and hospital administrators.

† It is anticipated that the 1967 legislature will amend present legislation to provide *civil* liability immunity for those required to report.

points of the individual case, or it may be merely a note or cover letter that accompanies copies of the medical findings and case history. Where x-rays reinforce the initial diagnosis of battered child, physicians and surgeons should incorporate such findings in their reports. It is recommended that the report also contain:

1. The names and addresses of the child and his parents or whoever is caring for him;
2. The child's age;
3. The nature of the child's condition, including any evidence of previous injuries or disabilities;
4. Any other information that may be helpful in establishing the reason for the abuse and the identity of the perpetrator(s).

A suggested form for reporting cases of child abuse may be obtained from the State Department of Public Welfare, 1 West Wilson Street, Madison, Wisconsin 53702.

GOVERNMENTAL RESPONSIBILITY

The first responsibility of the county welfare department (or county children's board) is to see that the child is safe while a complete investigation is made. If the child is not hospitalized the question of whether he should be removed from his home, even temporarily, must be dealt with. In some cases such action may not be necessary; in others, arrangements will have to be made by the county welfare department to place the child in the temporary care of relatives or friends or in an emergency foster home.

Having received a report of an abused child the social worker may need to talk to the person making the report to aid in evaluating the child's parents or his home. The worker will meet with the parents, and will probably interview relatives, neighbors, law enforcement officers, and others who may have information that will help determine the true cause and nature of the child abuse.

The main concern will be to find out whether abuse is likely to be repeated if the child is returned to the home. The next step will be to develop a counseling plan aimed at stabilizing the family to prevent further abuse.

If removal of the child is necessary the county welfare department will petition the juvenile court for custody and will then place the child in a foster home or suitable child care institution. Meanwhile, the county welfare department will help the parents prepare for the time when their child may be safely returned to them.

SCHEDULE—ORTHOPEDIC FIELD CLINICS

January 1, 1967–June 30, 1967

STATE DEPARTMENT OF PUBLIC INSTRUCTION

BUREAU FOR HANDICAPPED CHILDREN—CRIPPLED CHILDREN DIVISION

MADISON, WISCONSIN 53703

Location	*Date*	*Location*	*Date*
Ashland	February 15 and 16	Eau Claire	April 19 and 20
Manitowoc	February 22 and 23	Sheboygan	April 26 and 27
Marinette	March 1	Rhinelander	May 3 and 4
Stevens Point	March 8	La Crosse	May 17 and 18
Racine	March 15 and 16	Chippewa Falls	May 24 and 25
Kenosha	March 21 and 22	Lancaster	June 6
Superior	April 5	Darlington	June 7

FOR: Clinics conducted by the Crippled Children Division of the Bureau for Handicapped Children are for persons under 21 years of age, who are referred by their family physician for orthopedic diagnosis and consultation. The reports of the examinations are then sent to the referring physician following the clinic.

REFERRAL FORMS: Forms for the purpose of referral may be obtained from the Bureau for Handicapped Children and should be requested well in advance of the clinic date. Medical referral forms are made up for the individual clinic so when requesting same be sure to state approximately how many forms are needed and for which clinic or clinics. It is important that we know well in advance the number of persons desiring clinic service so the case load will not exceed clinic facilities.

CLINIC APPOINTMENT: Families who return the signed referral form will be notified of the date and hour of their appointment a few days before the clinic. Parents and physicians are invited to attend the clinic with the child.

ADDRESS CORRESPONDENCE: Bureau for Handicapped Children, 110 North Henry Street, Madison, Wisconsin 53703.

Declaration of Helsinki

RECOMMENDATIONS GUIDING DOCTORS IN CLINICAL RESEARCH

Adopted by the World Medical Association in 1964

IT IS THE MISSION of the doctor to safeguard the health of the people. His knowledge and conscience are dedicated to the fulfillment of this mission.

The Declaration of Geneva of The World Medical Association binds the doctor with the words: "The health of my patient will be my first consideration" and the International Code of Medical Ethics which declares that "Any act or advice which could weaken physical or mental resistance of a human being may be used only in his interest."

Because it is essential that the results of laboratory experiments be applied to human beings to further scientific knowledge and to help suffering humanity, The World Medical Association has prepared the following recommendations as a guide to each doctor in clinical research. It must be stressed that the standards as drafted are only a guide to physicians all over the world. Doctors are not relieved from criminal, civil and ethical responsibilities under the laws of their own countries.

In the field of clinical research a fundamental distinction must be recognized between clinical research in which the aim is essentially therapeutic for a patient, and the clincal research, the essential object of which is purely scientific and without therapeutic value to the person subjected to the research.

I. BASIC PRINCIPLES

1. Clinical research must conform to the moral and scientific principles that justify medical research and should be based on laboratory and animal experiments or other scientifically established facts.

2. Clinical research should be conducted only by scientifically qualified persons and under the supervision of a qualified medical man.

3. Clinical research cannot legitimately be carried out unless the importance of the objective is in proportion to the inherent risk to the subject.

4. Every clinical research project should be preceded by careful assessment of inherent risks in comparison to forseeable benefits to the subject or to others.

5. Special caution should be exercised by the doctor in performing clinical research in which the personality of the subject is liable to be altered by drugs or experimental procedure.

II. CLINICAL RESEARCH COMBINED WITH PROFESSIONAL CARE

1. In the treatment of the sick person, the doctor must be free to use a new therapeutic measure, if in his judgment it offers hope of saving life, reestablishing health, or alleviating suffering.

If at all possible, consistent with patient psychology, the doctor should obtain the patient's freely given consent after the patient has been given a full explanation. In case of legal incapacity, consent should also be procured from the legal guardian; in case of physical incapacity the permission of the legal guardian replaces that of the patient.

2. The doctor can combine clinical research with professional care, the objective being the acquisition of new medical knowledge, only to the extent that clinical research is justified by its therapeutic value for the patient.

III. NON-THERAPEUTIC CLINICAL RESEARCH

1. In the purely scientific application of clinical research carried out on a human being, it is the duty of the doctor to remain the protector of the life and health of that person on whom clinical research is being carried out.

2. The nature, the purpose and the risk of clinical research must be explained to the subject by the doctor.

3a. Clinical research on a human being cannot be undertaken without his free consent after he has been informed; if he is legally incompetent, the consent of the legal guardian should be procured.

3b. The subject of clinical research should be in such a mental, physical and legal state as to be able to exercise fully his power of choice.

3c. Consent should, as a rule, be obtained in writing. However, the responsibility for clinical research always remains with the research worker;

We, the undersigned medical organizations, endorse the ethical principles set forth in the Declaration of Helsinki by the World Medical Association concerning human experimentation. These principles supplement the principles of medical ethics to which American physicians already subscribe.

American Federation for Clinical Research
American Society for Clinical Investigation
Central Society for Clinical Research
American College of Physicians
American College of Surgeons
Society for Pediatric Research
American Academy of Pediatrics
American Medical Association

it never falls on the subject even after consent is obtained.

4a. The investigator must respect the right of each individual to safeguard his personal integrity, especially if the subject is in a dependent relationship to the investigator.

4b. At any time during the course of clinical research the subject or his guardian should be free to withdraw permission for research to be continued.

The investigator or the investigating team should discontinue the research if in his or their judgment, it may, if continued, be harmful to the individual.

BLOOD GROUPING TEST FOR IDENTIFICATION

In an illegitimacy action, the trial court may order the mother, child, alleged father and others to submit to one or more blood grouping tests to determine whether the defendant can be excluded as the father of the child. The tests may be ordered, however, only after it has been determined that the tests would be relevant to the prosecution by the mother or the defense by the alleged father.

The results of the test are admissible only to prove that the defendant is not the father. Results which show only that the defendant might be the father are not admissible. Such tests must be conducted by a duly qualified physician or physicians each of whom has specialized in the field of clinical pathology or who possess a certificate of qualification as a certified pathologist issued by the American Board of Pathology.

Whenever relevant in a civil action to determine the parentage or identity of any child, person, or corpse, the court must direct any party to the action and any person involved in the controversy to submit to one or more blood tests. The results of the tests constitute conclusive evidence where exclusion is established and are receivable as evidence, but only in cases where a definite exclusion is established.

Reference: Sections 52.36 and 885.23, Wisconsin Statutes, 1965.

Consents for Treatment of a Minor

A minor is defined by the Wisconsin Statutes as a person who is under 21. Consents to treatment are necessary for minors as well as for those over 21. Consents may be oral as well as written, but unless a physician can produce disinterested witnesses with good memories, he will do better to have the consent in writing.

The proper person to consent to surgery or other treatment of a minor is either parent, or if neither parent is living, the minor's court appointed guardian. A physician is not legally protected by a consent signed by a relative of a minor, other than a parent, unless such relative has been appointed as such minor's legal guardian by a court.

There are two exceptions to the above general rule. First, in an *emergency*, a consent is *not* necessary if the parents or guardian cannot be located, and, in the judgment of the physician in charge and of consultants where consultation is practical, immediate treatment is necessary to save life or to prevent the deterioration or aggravation of the condition of the patient.

The legal reason for the above exception is that in an emergency the law *implies* the consent of the patient, or in the case of a minor, of his parent or guardian. BECAUSE THE LAW DOES NOT IMPLY CONSENT BEYOND THE TREATMENT ACTUALLY NECESSARY TO MEET AN EMERGENCY, THE PHYSICIAN MAY SAFELY TREAT ONLY THE EMERGENCY CONDITION ITSELF, AND NOTHING ELSE, WITHOUT ACTUAL CONSENT OF A PARENT OR GUARDIAN.

Second, an *emancipated* minor can give a consent for medical treatment, including surgery. A minor is emancipated (1) who is lawfully married, or (2) whose parents have divested themselves of their legal right of control over him. Typically a minor in the latter situation is one who is self-supporting. An unmarried minor attending school away from his home community is not emancipated by virtue of that fact alone.

A physician who has any doubt whether a minor is emancipated, should require the consent of a parent or the legal guardian before proceeding with non-emergency treatment.

Note: On the subject of consents generally, see 1958 *Blue Book* issue of this JOURNAL, Vol. 57, issue 1, pages 4–58.

What Every Doctor Should Know about Workmen's Compensation

INFORMATION about the Workmen's Compensation Act is news of direct interest to virtually every physician in Wisconsin, irrespective of his specialty or location.

The law applies to more than 70,000 employers who have three or more employees. Farmers are excluded unless they employ 6 or more employees on any 20 days in a calendar year. If any one of the more than one million employees covered by the act receives an injury or disease during the course of his employment, the law makes the employer liable to provide certain indemnities and to provide or pay for such medical attention as may be needed to bring about rehabilitation.

Five points of advice will aid every physician in dealing with Workmen's Comp.:

★ Have your name listed on the State Medical Society's Workmen's Compensation panels if you want to treat employees under Workmen's Compensation.

★ Learn how to estimate disability according to the standards set up by the Industrial Commission of Wisconsin. Other standards or schedules are fine for your own information, but only the Commission's standards are authoritative in Wisconsin.

★ Submit your reports promptly to the Commission. Delay may mean withholding of compensation to the injured employee and professional fees to the physician. Quite often the unexpected misfortune places the employee in urgent need of compensation.

★ Fill out the report forms carefully, completely. Learn the terminology of the statutes concerning compensable employment disability.

★ Don't be afraid to ask questions. Contact either the State Medical Society, Box 1109, Madison, Wis. 53701, or Mr. R. E. Gintz, Director of Workmen's Compensation, Hill Farm State Office Building, 4802 Sheboygan Avenue, Madison, Wis. 53702.

The following article provides answers to the questions most commonly asked of the State Medical Society in its past 30 years of experience with the Workmen's Compensation Act.

Q. Since the Workmen's Compensation Act is designed to provide protection to the working men of Wisconsin, how does the physician get into the picture?

A. When a workman has, or thinks he has, an injury or disease resulting from his employment, a report from the employer or a claim by the workman is filed with the Industrial Commission. To establish this claim a medical report verifying and specifying the workman's injuries or diseases and the degree of disability is necessary. The Industrial Commission and the employer or insurance company use the doctor's disability report to help determine the amount of compensation. If it turns out that the employer is obligated to provide or pay for necessary medical attention, he is required to supply the injured employee with "such medical-surgical and hospital treatment, medicines, medical and surgical supplies, crutches, artificial members, appliances . . . as may be reasonably required to cure and relieve from the effects of the injury."

Q. How does the Industrial Commission determine whether the claim is justified?

A. Three essential elements must be ascertained before an award can be made to an injured claimant. They are an employer-employee relationship; the employer must be subject to the Act; and it must be proved that the injury or disease was suffered or acquired in the course of employment.

Q. Can any physician treat employees under the Workmen's Compensation Act?

A. Any licensed physician, as a general rule. The Workmen's Compensation Act requires the employer to maintain a "reasonable number" of competent and impartial physicians ready to undertake the treatment of his employees and to permit the employees to make a choice of their physicians from among them.

Prior to 1939 a great many companies had limited panels. However, during that year the State Medical Society of Wisconsin and the insurance companies selling workmen's compensation insurance in the state entered into a joint agreement to enlarge the panels through the voluntary cooperation of employers and the insurance companies. The object

was to give the workmen of Wisconsin an opportunity to secure virtual free choice of physician.

This agreement has come to be called the "Open Panel System." Any member of the State Medical Society of Wisconsin who indicates his willingness to serve injured employees may have his name included on the panel, which is prepared for each county in the state. These panels are certified to the insurance companies and are distributed to each employer of three or more persons in the state. This system has been so successful that more than 80% of the workmen in Wisconsin now have a wide choice of physicians.

Q. How does a doctor get on the panel?

A. About every three years the State Medical Society of Wisconsin circulates each of its members. The doctor is asked if he wants to be listed on the panel. If he completes the form and returns it promptly, he will automatically be listed on the next panel. However, a physician may at any time request listing or removal. The panels will not be changed until the next printing, but inquiries directed to the office of the Society will be answered on the basis of the current participation of each member.

Q. Does the doctor take on any obligations if he applies for a listing on the panel?

A. Yes. He agrees to have consultation when this is requested by the insurance carrier. He also agrees to communicate with the insurance carrier on the matter of choice of the consultant so that the consultant might be mutually agreed upon. Some exceptions will occur to these agreements, but the exceptions should be limited only to emergencies.

Q. Are any other practitioners listed on the "Open Panel"?

A. No. The State Medical Society panel lists only members of the State Medical Society. If any panel distributed by an insurance carrier contains the names of any other persons, it is not a panel approved by the State Medical Society.

Panels are distributed by another group of unlimited licensees, but these are not part of the State Medical Society program.

Q. What happens in the event of dispute or complaint about the handling of certain cases?

A. Under the "Open Panel" agreement a "State Conference Committee" is set up. It includes two representatives of the insurance carriers and two representatives of the State Medical Society. The duties of this committee are to mediate, if possible, cases where the insurance companies complain that the attending physician has neglected or refused to furnish the reports reasonably necessary, cases where insurance carriers are charged with having unreasonably interfered with what is properly in the discretion or control of the attending physician, and differences that may arise between the attending physician and the insurance carrier relative to remuneration; to review any situation in which it is claimed there is a violation of ethics; and to hear complaints relative to the competency of those serving on the panel and remove their names from it if an investigation shows that such complaints are justified. Cases involving medical ethics will be referred to the board of censors of the appropriate county medical society. Local committees may be designated to investigate and report back to the "State Conference Committee" with recommendations when it seems necessary. Mediation will be attempted only in cases in which the physician involved is on the listing provided by the State Medical Society.

Q. How is the physician paid for services rendered to an injured workman who is covered under the act?

A. Usually the employer or his Workmen's Compensation insurance company pays the physician. This is true where it is conceded that the injury was sustained on the job and that the treatment rendered was necessary because of such injury.

Where there is a dispute and it is found by the Industrial Commission that the case is not covered by the Workmen's Compensation Act, the employer is still liable for treatment authorized by him. On the other hand, the employee–patient is liable for unauthorized treatment. The Industrial Commission determines what treatment is covered under the Workmen's Compensation Act.

Q. What about other situations?

A. Where the employer fails to furnish a panel, the injured employee has complete free choice. Then the Industrial Commission has power to determine the reasonable necessity for treatment and the reasonable amount of the medical bill for which the employer is responsible.

Sometimes the employee does not give notice of his need for treatment, or he refuses to accept the panel physician. Then the employer has no liability and the Commission no jurisdiction to determine necessity or reasonableness.

Q. Are the claim reports filed by the physician kept confidential?

A. As a general rule communications from a patient to an attending physician are privileged. The Workmen's Compensation Act creates an exception to the law of privilege. The law provides that any physician attending a Workmen's Compensation claimant furnish to the employee, the employer, the Workmen's Compensation insurance carrier or the Commission information and reports relative to a compensation claim. The Commission explains that it is a practical necessity for physicians to furnish information. Physicians will not be required to disclose confidential communications transmitted to them unless such information is necessary to a

proper disposition of the claim. The physician's testimony before the Commission should be absolutely fair, factual and unbiased.

Q. Does this mean that the physician need not divulge any information to the employer about an employee who files a claim?

A. The physician most certainly is not required to disclose information communicated to him by the employee when it goes beyond the information required for a proper disposition of a claim. However, under the Workmen's Compensation Act, the employer, the insurance company, or the Industrial Commission has the right to request a complete report on an injured employee. So, as a matter of fact, the physician may legally transmit to the employer such information as is required for a proper disposition of the claim. He is not privileged to release any other information than that ordinarily required for the handling of the claim.

Q. What is the doctor's role in disputed cases?

A. Naturally, there will sometimes be disputes between the employee and the employer or his compensation carrier as to whether the workman has suffered an injury in the course of his employment for which he is entitled to compensation. The physician may be asked to act as an expert witness for either the injured workman, the employer, or his insurance company. Therefore, doctors must be interested in whether the injury or disease was suffered in the course of employment and arose out of the employment.

When the employer or his insurance company agrees to the fact that the injury or disease was due to the employment, the question then is confined to the extent of liability on the part of the employer. In many instances this means the physician must be prepared to explain the disability in terms of its effect on the employee.

Q. What about "outside" physicians appearing as expert witnesses?

A. Sometimes the injured workman calls upon a physician other than the attending physician to appear as an expert witness in his behalf. In such cases the physician must make a careful study and examination of the whole question and be prepared to present his opinion adequately and carefully. The Commission is authorized in the interest of a fair and impartial hearing to order examinations by physicians who are wholly independent of either the claimant, the employer, or the insurance carrier. Such physicians are witnesses of the State of Wisconsin at the time they appear to testify relative to the claim of the injured workman.

Q. How much is paid as a witness fee when physicians testify?

A. Ordinary witness fees are paid unless the physician performs work in preparation at the request of one of the parties to the dispute. In those cases in which the physician appears as an expert witness for the injured employee, and seeks to have his fees paid directly out of the compensation award, it must be expected that the Industrial Commission will endeavor to protect the employee through permitting only what it considers to be a reasonable allowance for the expert witness. Each bill necessarily depends on the circumstances of the individual case. The State Medical Society suggests to its members the practical necessity of submitting itemized statements substantiating the charges made by the expert witness. With an itemized statement before it, the Industrial Commission is in a better position to judge the work involved and the reasonableness of the charges of the physician.

Physicians must also keep in mind the fact that where an appearance as an expert witness is made for a claimant and no award is granted, they must look directly to the employee for payment. Likewise, where a physician treats an injured employee, and such treatment has not been authorized by the employer, and the Industrial Commission finds no liability on the part of the employer, the physician must look directly to his patient for payment.

Q. Must a physician obey a subpoena when only ordinary witness fees are paid?

A. Yes. Some physicians believe that they cannot be required to obey a subpoena unless an expert witness fee is paid to them. This is erroneous. Wisconsin courts have held that, except where there is a demand for preparation, every witness, expert or otherwise, must obey a subpoena upon payment of the ordinary witness fee.

Q. Are there special procedures for the handling of compensation claims of state employees?

A. In a sense, yes. The Commission is particularly explicit in its demands for itemized medical statements and for verification of the reasonableness of the medical charges in the case of state employees who file compensation claims.

Such cases require a report (on a form supplied by the Commission) from the attending physician, showing the nature of injury and the extent of disability. In addition, the physician and/or hospital must provide an itemized bill showing services rendered and charges made.

In any case in which disability results or medical expense is involved, a statement is required from the employee (on a form supplied by the Industrial Commission) to the effect that he was injured in the course of his employment, reciting time and place of injury, the reasons for its occurrence, and the nature of injury, and stating all expenditures incurred for medical, surgical, and hospital treatment and medicines to the time of the claim, whether the claim is made for disability and, if so, what period of temporary disability and what permanent

disability is claimed, and what salary has been paid by the state during the period of disability. If bills have been paid by the injured, receipts are to be attached.

Further, these cases require a statement from the employing department stating whether injury occurred in the course of employment and whether treatment is believed necessary as claimed. This will be made in conjunction with the employee's statement and on the same form. If the department is unable to make a statement, the reason is to be stated.

Q. Can you explain non-schedule injuries?

A. Non-schedule injuries are those to some portion of the body other than the legs, arms, ears, or eyes, or their constituent parts. In other words, non-schedule injuries are to the torso or to the head, exclusive of eye and ear injuries.

Permanent disability for such injuries is estimated on the basis of the comparison between the nature of *the injury* and the nature of *an injury* causing permanent total disability of the entire body as a working unit.

Q. Now what is meant by schedule injuries?

A. Schedule injuries are estimated upon a different basis which bears no relation to wage loss. In these cases *the comparison is between the injured limb and a normal limb*, having in mind all of the useful functions of the limb or organ. Schedule injuries apply to arms, legs, eyes, and ears, as well as any constituent part of these members and organs. Disability is measured as a percentage loss of use as compared to amputation at a designated joint or joints or, in the case of the eye or ear, as a percentage loss of use compared to total loss of sight or hearing.

The estimate of disability has no reference to any particular occupational use to which the member is to be put. For example, the violin player who has lost a digit vital for the purpose of playing may consequently lose a great deal in wages. However, he receives exactly the same number of weeks compensation as does the laborer who may be able to perform his work nearly as efficiently as before even with the loss of a digit.

The law fixes the value of each finger, thumb, toe, hand, arm, foot, and leg at various joints. In the estimation of disability the physician takes into consideration the percentage of loss of function which has resulted to the given unit as of the joint at which disability exists. If disability is between joints, he considers the percentage of loss of function at the joint proximal to the point of disability. For example, if there is disability proximal to the wrist, but no disability above the elbow, the comparison is of the injured arm with a normal arm at the elbow or, put conversely, with an arm which has been amputated at the elbow.

In every case of schedule injury where there is a certain limitation of motion with no other element of disability involved, the functional disability is the same as in all identical cases. Therefore, the estimate in such cases should be uniform. If the employee has lost his ability to raise his arm at the shoulder beyond the horizontal level and has no other disability, the estimate should manifestly be the same in his case as in all other cases where the limitation of motion is identical and where no other disability has resulted. In case of schedule injuries the Commission has adopted a guide table for disability due to losses of motion.

Q. Is there anything to help the physician in rating disabilities?

A. Yes. The Commission worked closely with the State Medical Society and physicians in establishing a schedule of related disabilities to serve as a guide in rating disabilities *short of amputations or total loss of all function.* In this guide, for example, where the loss of the function is represented by a limitation of active elevation of the arm in all directions to 90 degrees, but otherwise normal, *the loss is interpreted at 20% of the arm at the shoulder.*

Elements of disability include amputations, limitation of motion, pain, weakness, lack of endurance, and deformity. The disability is the percentage loss of use as compared to amputation at the affected joint or joints. When amputation is between joints, the loss is 100 per cent at the amputated joint, plus the percentage of bone loss at the next phalanx as determined by comparative x-rays. This is the loss for amputation and additional disability rating may be due for additional disability factors of the remaining portion of the limb. The Commission can determine the percentage of disability because of loss of motion from its guides, but the physician's opinion must be given as to the percentage of loss at each joint or joints that are affected for other elements of disability.

In all of the cases where landmarks have been adopted, the percentage of disability must vary as other conditions exist which constitute elements of functional loss. If, for example, in addition to limitation of motion, there is disabling pain and/or weakness, a percentage must be added for these elements. As the Commission has adopted these landmarks to measure disabilities only for loss of motion, the physician must exercise his best judgment as to the percentage to be added for other items which may conduce to disability. It should be clearly indicated at what joint or joints the disability is measured.

Q. What if the physician disagrees with these methods of estimating disability?

A. Most parties are in general agreement as to the essential justice of the current provisions. Obviously, the physician's methods of estimating must be in accordance with the law regardless of his personal feelings as to the correctness or justness of the law. Any feelings that the law is harsh, inadequate, or inequitable in certain individual cases

Industrial Commission Guide for Estimating Disabilities

The following guide represents per cent of loss of use as compared with amputations at involved joints. This guide measures disability for loss of motion only. Other factors of disability such as pain, weakness, loss of sensation, etc., are to be established separately.

Shoulder

Total ankylosis at the shoulder with arm at side, scapula fixed	75%
Total ankylosis at the shoulder with arm at side, scapula free	55%
Limitation of active elevation to 45° but otherwise normal	35%
Limitation of active elevation in all directions to 90° but otherwise normal	20%
Limitation of active elevation to 135° but otherwise normal	5%

Elbow

Ankylosis of elbow joint at 45° less than full extension (radio-ulnar motion destroyed, hand 45° less than fully pronated)	60%
Total ankylosis of arm at elbow at right angles	
With radio-ulnar motion intact	50%
With radio-ulnar motion destroyed (hand 45° less than fully pronated)	70%
Ankylosis of arm at elbow at 45° less than full extension with radio-ulnar motion intact	45%
Limitation of motion of elbow joint (radio-ulnar motion unaffected)	
Remaining range, 90°–135°	20%
Remaining range, 135°–180°	35%
Ankylosis of radius and ulna, estimated at elbow joint (hand 45° less than fully pronated)	20%

Wrist

Ankylosis, straight position	25%

Fingers

Complete ankylosis Thumb	Mid-position	Complete Extension
Distal joint only	25%	35%
Proximal joint only	15%	20%
Distal and proximal joints	35%	65%
Distal, proximal and carpometacarpal joints	85%	100%
Fingers		
Distal joint only	25%	35%
Middle joint only	75%	85%
Proximal joint only	40%	50%
Distal and middle joints	85%	100%
Distal, middle, and proximal joints	100%	100%

Fingers

Loss of Motion Fingers	Loss of flexion	Loss of use	Loss of extension	Loss of use
Distal joint only	10%	= 1%	10%	= 2%
	20%	= 2%	20%	= 4%
	30%	= 3%	30%	= 6%
	40%	= 5%	40%	= 8%
	50%	= 10%	50%	= 15%
	60%	= 15%	60%	= 20%
	70%	= 20%	70%	= 30%
	80%	= 25%	80%	= 40%
			100%	= 60%
Middle joint only	10%	= 5%	10%	= 2½%
	20%	= 10%	20%	= 5%
	30%	= 15%	30%	= 10%
	40%	= 25%	40%	= 15%
	50%	= 40%	50%	= 30%
	60%	= 50%	60%	= 50%
	70%	= 60%	70%	= 70%
	80%	= 70%	80%	= 90%
			100%	= 100%
Proximal joint only	10%	= 5%	10%	= 2½%
	20%	= 10%	20%	= 5%
	30%	= 15%	30%	= 15%
	40%	= 20%	40%	= 20%
	50%	= 25%	50%	= 25%
	60%	= 30%	60%	= 40%
	70%	= 35%	70%	= 75%
	80%	= 40%	80%	= 85%
			90%	= 100%

(Where there is partial disability to two or more phalanges the estimate of the physician should take into consideration the greater cumulative effect because of such multiple disabilities. By analogy the allowances for complete ankylosis, where two or more joints are affected, may be used as a guide for comparison as to the greater allowance to be made because of the combined disabilities to two or more phalanges.)

Hip

Ankylosis in alignment for normal standing position	50%
Shortening of leg (no posterior or lateral angulation, age 50 or less)	
1 inch	7%
1½ inches	14%
2 inches	22%

Knee

Ankylosis at 170°	40%
Limitation of motion, remaining range 135°–180°	20%

Ankle

Ankylosis — favorable position 10°–15° equinus without loss of inversion and eversion	30%
Ankylosis—favorable position with loss of inversion and eversion	40%
Loss of inversion and eversion with full dorsi and plantar flexion remaining	15%

Physicians should submit their reports promptly to the Commission. Delay may mean withholding of compensation to the injured employee and of professional fees to the physician.

should never be allowed to influence the physician either in treating or in estimating disability.

Q. Should the doctor suggest the basis for settlement?

A. No. The physician who estimates disability should never concern himself with the result in number of weeks or in dollars. He should confine himself strictly to the medical field in estimating the disability on a functional basis. It is the function of the employer and the carrier, not that of the doctor, to propose the basis for settlement. The doctor's function is to report his factual findings with the probabilities and possibilities which may be involved, leaving to the employer or carrier the suggestion as to whether or not settlement should be made and upon what basis. Obviously, the physician should not be influenced by the amount of compensation which may be paid to the injured.

Q. Does the physician have any part in the computation of compensation?

A. Physicians should not attempt to compute the amount of compensation to become due. The law fixes the amount to be paid on the basis of disability which has resulted. This amount may be much greater or smaller than a particular physician might consider to be equitable. Computation of compensation based on estimates of disability is a function of the Industrial Commission. The attempts of physicians to compute sometimes result in erroneous figures and cause confusion and misunderstanding, both on the part of the physician and the injured person.

Q. In estimating disabilities in the schedule group, would 50% loss of motion mean 50% loss of function of the limb?

A. No, not necessarily. Loss of use and loss of motion are not identical. All functions of the limb, such as motion, freedom from pain, strength, coordination, quickness of action, endurance, sensation, and so forth, must be considered. The physician must assign to each factor the percentage which he considers represents the proportion of functional use of that factor as compared with all functions of a normal member. Also, to each factor must be applied the percentage of loss of motion of the particular factor which has resulted. The total of the resulting percentages constitutes the percentage of disability to the member involved.

When disability consists of loss of motion of a finger, the physician need not convert the degrees or percentage loss of flexion or extension into loss of use as shown by the guide on page 31, since the Commission can do this from the information supplied. The physician should clearly set forth the degrees or percentage loss of flexion and/or loss of extension at each joint of each finger that is affected. Normal extension is in a position of 180 degrees at all joints. Normal flexion at the distal joint of the finger is taken to be 70 degrees in the absence of any indication to the contrary. At the second or middle joint, normal flexion is considered to be 100 degrees and at the proximal 90 degrees. For example, a 30-degree loss of extension at the middle joint is 30% loss of extension rather than 16%, which many physicians often indicate. This is true because 30% loss of extension must be a percentage of the total motion of the joint, in this case the middle joint, which has only 100 degrees of motion.

Q. What kind of forms are used in reporting disabilities under the Compensation Act?

A. The Commission has adopted special forms for use of physicians. If the Commission is to pass upon a disability, it is necessary that the physician's report contain all of the information requested on this form as a basic minimum. If for some reason the form is not used by the physician, he should make certain that the requirements of the form are met. This will save returning the form to the physician with a request for supplementary report.

Q. If the physician completes the form properly, does this eliminate the need for him to personally appear in cases before the Commission?

A. Approximately 90% of all injury claims are paid by the employer or insurance company without dispute and on the basis of reports submitted. Where dispute arises and formal hearing becomes necessary, the Commission has a type of physician's report form which may eliminate the necessity of having the physician appear personally. The law provides that the contents of certified or verified medical and surgical reports by physicians licensed in and practicing in Wisconsin presented by claimants for compensation shall constitute prima-facie evidence as to the matter contained therein, subject to such rules and such limitations as the Commission may prescribe. Likewise, reports of physicians and surgeons, wherever licensed and practicing, to whom the claimant has been sent for examination and treatment by the employer or insurer, are available for evidence provided the doctor consents to subject himself to cross-examination. The use of the form mentioned above makes it unnecessary for the physician to appear personally in some cases, especially where the issue and dispute is of a simple nature and it is desirable to avoid expense to the applicant in arranging for the personal appearance of the physician at the time of the hearing.

Q. Are special forms used in cases of loss of vision?

A. Yes. These forms will be supplied to physicians upon their request, along with rules for determining loss of visual efficiency caused by industrial injury.

Q. Are there any special forms for estimating loss of hearing?

A. In cooperation with the medical profession, insurance carriers, industry, and labor, the Commission has worked out formulas for determining the loss of hearing suffered during the course and as a result of particular employments. These formulas are a guide at the present time and are primarily for the assistance of the examining physician. Copies of the formulas and associated material may be obtained by writing the Commission.

Q. Are there any suggestions for completing the forms required by the Commission?

A. The Commission needs a full report covering all factors if it is to be able to fix the percentage of disability. Therefore, the doctor should set out in detail the elements which constitute disability. He should state as nearly as possible the weight and percentage of loss which has been ascribed to each. He should also set out his opinion as to the ultimate total percentage of disability which has resulted. This enables the Commission to check the report with its standards and to arrive at an intelligent and uniform conclusion.

Q. What about terminology?

A. Many reports have to be returned to physicians because of use of terminology which does not follow that set out in the statute. For example, the statute refers to the thumb, index, middle, ring and little fingers, and to disability at the distal, second, and proximal joints. Some physicians refer to the first, second, third, and fourth fingers, and some designate the thumb as the first finger. Some physicians speak of the interphalangeal joints, and sometimes of the first, second, and third joints, leaving confusion as to the point of measurement. The law designates distal, second, and proximal joints. If physicians will use the language of the statute, a good deal of confusion and necessity for supplementary reports can be avoided.

Q. Can a physician use his own standard for measurement of disability?

A. No standards or schedules not adopted by the Commission have the approval of the Commission. Only those adopted and published by the Commission itself should be considered as authoritative or as representing the Commission's thought as to percentages of disability based on certain functional losses. Obviously, physicians will have various ideas as to standards and schedules for estimating disability. However, they should use these as a matter of interest. Their opinions should be based upon their own examination and analysis and by reference to the standards which the Commission has adopted.

Q. To whom should the physician furnish reports with regard to a compensation claim?

A. Regardless of any other statutory provisions, the law specifically provides that any physician attending a Workmen's Compensation claimant may furnish to the employee, employer, Workmen's Compensation insurance carrier, or the Commission information and reports relative to a compensation claim. It further provides that a physician from outside Wisconsin may testify in compensation proceedings if he is licensed for the place of his residence or practice.

Q. How does a physician get the needed report forms?

A. Simply write to the Industrial Commission, Hill Farm State Office Building, Madison, Wisconsin.

Q. Where can the physician go for additional help in handling compensation cases?

A. The Workmen's Compensation Act and its administration is necessarily highly technical. The panel physician will find it easier to deal with the employer, the insurance carrier, and the patient if he has a reasonable understanding of its operation. Both the office of the State Medical Society and the Industrial Commission stand ready to assist in solving some of the problems facing the physician who treats patients entitled to or claiming benefits under the act. Inquiries may be directed either to the State Medical Society, Box 1109, Madison, Wis. 53701, or to Mr. R. E. Gintz, Director of Workmen's Compensation, Hill Farm State Office Building, 4802 Sheboygan Avenue, Madison, Wis. 53702.

TAX GUIDE AVAILABLE

The Wisconsin Taxpayers Alliance has announced that the 1967 edition of TAXES, its annually published tax guide is now available. TAXES provides easy-to-follow instructions on how to fill out both state and federal income tax returns. TAXES also includes information on all state and federal taxes levied in Wisconsin.

Orders should be sent to the Wisconsin Taxpayers Alliance, Madison, Wisconsin 53703. The cost is 50 cents a copy.

Physician and Hospital Records Retention and Inspection

IT IS AGREED that ownership of medical and hospital records rests, respectively, with the physician and the hospital. The doctor-patient-hospital relationship has been considered by the legislature and the courts. They have declared it to be in the public interest that the patient have access to relevant records concerning his medical care and treatment.

Because physicians, hospital personnel, patients and others are not always clear as to their respective rights and obligations, and because there is uncertainty as to what constitutes a "medical record" or "hospital record", representatives of the State Medical Society of Wisconsin and the Wisconsin Hospital Association have jointly undertaken an *Interpretation* on this subject which is reprinted in full beginning with page 36 hereof.

The *Interpretation* was approved by the Council of the State Medical Society and the Board of Trustees of the Wisconsin Hospital Association. It contains recommendations and suggestions regarding hospitals' and physicians' responsibilities under Section 269.57 (4), which was enacted as part of Chapter 301, Laws of Wisconsin, 1959.

Patient and hospital records today include not only the written history, diagnosis, treatment, prognosis and related summaries, but such additional items as: x-rays, laboratory reports and correspondence with other physicians relative to a particular patient and to a particular condition.

Since a patient does have a general right to inspect his medical and hospital records, the question how long to retain records is automatically raised.

For purposes of this article patients can be classified into three legal categories. Each category calls for retention of records for different periods. These are patients (1) over 21 who are mentally competent; (2) over 21 who are mentally ill; and (3) under 21.

Among others, the following reasons for retention of patient records, whether in original or reproduced form, must be considered:

1. To aid medical science; also to facilitate the care of a particular patient who requires treatment or hospitalization at a later time.
2. To provide a record for the assistance of the patient in enforcing his claim for injuries against others than the physician, hospital, or members of their respective staffs.
3. To assist the physician, hospital, a member of the medical or nursing staff, or other personnel in defending against an allegation of negligence made by or on behalf of the patient.
4. To assist the physician or hospital in collecting an unpaid debt due from a patient.

Recommendations

The following recommendations apply to each of the foregoing reasons for retention of records above noted.

1. As to the length of time for retaining records as an aid to medical science or to the patient himself, this will depend in part upon the facilities of the physician's office or the size and character of the hospital and will necessarily involve the judgment of the particular physician or of the medical staff of the hospital. In any event this is a matter of medical judgment and not of legal considerations.
2. A patient of legal age has *3* years within which to sue *for personal injuries*. If a patient elects to sue on *a contract* rather than for alleged *negligence*, he has *6* years in which to do so. In rare instances which would almost never apply to a patient-physician relationship, he might have up to 20 years. Such unusual situations would ordinarily be known to the physician's attorney. To aid the patient in enforcing his claims against others, it is recommended that records be retained for at least 6 years. We are unaware of any *legal* requirement for accommodating a former patient longer than the suggested 6 years, although there may be sound reasons for retaining them longer. No statute of limitation runs where fraud can be established.
3. The period recommended for retention of patient records to defend against an allegation of negligence would depend upon the category into which the patient falls. The principal categories can be summarized as follows:
   A. If the patient is over 21 and mentally competent, the Wisconsin Statutes require that he start an action for alleged negligence within 3 years after the alleged act.
   B. If the patient is over 21 and mentally ill at the time of his treatment or hospitalization,

or becomes so within 3 years thereafter, suit must be brought on his behalf, or by him if he recovers, within a maximum of 8 years.

C. If the patient is a sane minor at the time of the treatment or hospitalization, he must sue for the alleged negligence by the time he reaches 22, unless his guardian did so before he became of age.

4. To the extent that patients' records are retained to assist in collection of accounts, such claims must be enforced by the physician or hospital within 6 years of the time it was incurred, unless such time was extended by act of the person owing the account.

An accurate and durable reproduction of the record on microfilm or similar process is as fully admissible before a court as the original itself. *Therefore, the originals of your records, once they are microfilmed, may be destroyed. However, it is advisable to keep the original record for at least 3 years or until the patient has paid your bill.* The reasons for this recommendation are:

1. The original is in many ways more convenient to handle and to read than microfilm;
2. The opportunity for physical examination of an original patient record minimizes the chance of suspicion or an assertion that something is missing.

If you receive a request for examination and copying of records, it may not state what specific records are needed. Your records for that patient may go back for 20 years or more.

Before complying with the request of a patient to examine and copy his records, it is suggested that the physician confer, if practical, with the patient or his representative to ascertain *why* he needs his records copied for such a long period of time. If by any chance the records contain material relating to conditions which would be embarrassing to him, or which might involve other members of his immediate family, he might be very grateful to have the physician point this out and delete them from any preparation.

If practical, the physician might also ascertain who suggested the copying of records for such a long period. It could be important whether this was another physician, an insurance company, an employer, or an attorney for any of such parties.

Once the decision has been made how far back to go and just what portions of the total medical record are to be copied, the physician or hospital should *not* let the record leave the premises. For the information of physicians, the statute does *not* authorize the removal of medical or hospital records from the premises. Further, the physician or hospital should *not* permit *anyone* outside the staff to copy the record except in the presence of a staff member. Whether by intention or not, the physician or hospital might lose a portion of the record if they do not observe these precautions, and such loss could prove a serious handicap later.

Some physicians are requesting not only that the time periods to be copied from a medical record be specified but also that each particular illness be specified in the authorization from the patient.

A number of other precautions are indicated in the *Interpretation* of Chapter 301, Laws of 1959, which follows. The physician or anyone designated to handle this matter would do well to review the contents of the *Interpretation before* interviewing the patient or preparing such parts of the medical record as the physician concludes to furnish.

Needless to say, the physician should not proceed under any circumstances without a *written* authorization signed by the patient; and the physician should be satisfied that: (1) the signature is the patient's, (2) he is mentally competent to make the request, and (3) the information is not of the character which would be likely to cause him nervous or other damage. While it is true the patient has what looks like a rather direct and simple legal right, the fact also remains, as to any specific care and treatment furnished by the physician, that the latter has a continuing responsibility toward him for such care and treatment.

The 1963 Legislature authorized the personal representative or the beneficiary of a life insurance policy to sign an authorization in case of a patient's death. If you receive such an authorization you can ask the personal representative to provide you with a certified copy of his authority to act. This will take the form of "Letters Testamentary" or "Letters of Administration" which are issued by the County Court, Probate Branch. In the case of the beneficiary of life insurance, you can ask for a certified statement from the insurance company that (1) a policy on the patient was in force at the time of his death, and (2) that the person signing the authorization is the beneficiary under the policy. The duty to provide the physician is on the person seeking the information and the physician has no duty to release such information until he is satisfied that the person asking is so authorized.

Since no wording appears in the statutes prescribing the form of authorization to inspect and copy a patient's record, model forms are not recommended. Sample forms are included in the *Interpretation* which follows but they should not be construed as more than suggested guides designed primarily to make clear the illness and period for which inspection and copying are sought.

An Interpretation of Chapter 301; Laws of 1959

(Prepared jointly by The State Medical Society of Wisconsin and the Wisconsin Hospital Association)

1. Upon being presented with an authorization form for the inspection of medical records, physicians and hospitals must assure themselves that the patient did *in fact* sign the authorization, and that he was of *legal age* and had the *mental capacity* to know what he was signing. A minor or incompetent must act through his guardian, and the hospital or physician must take such precautions as are necessary to satisfy themselves that those signing are thereby authorized to effect the release of the records of the patient.

The hospital or physician must be assured that the *person presenting* the authorization to inspect or copy records is the *identical person named* in such instrument. So long as there is any prudent or reasonable doubt as to the identity of a person presenting authorization to inspect or copy records, the hospital administrator, or his representative, or the physician, depending upon which place the authorization is presented, is warranted in refusing to honor such authorization. The same is true if there is any substantial question as to the mental capacity of the patient or as to the authenticity of his signature.

On being satisfied that the authorization presented is properly signed, as previously outlined, and that the person presenting it is the person named therein, and that no question of mental capacity or of minority is involved, it then becomes the duty of the hospital, institution or physician to permit such person to inspect and copy "medical or hospital reports, photographs, records, papers and writings" concerning the care and treatment of such patient.

It is first necessary to determine what must be made available for inspection and/or copying. It is believed that under a strict interpretation of subsection (4) of the statute, the physician's records (office or hospital), and the hospital clinical record or chart should be presented. In the case of x-rays there seems to be some disagreement among legal authorities that they are part of the medical record as such or are technically photographs. It is advised that x-rays *not* be released unless by court order, and that they be inspected *only* under proper supervision (in the case of a hospital or other institution by a qualified physician, or in the event of his unavailability, by a person designated by the administrator; in the case of a physician's office, by the physician in charge, an associate, or the designee of either).

Administrators and physicians should be cautioned that the copies of the records should be made only under properly authorized supervision, and that the originals of the records cannot be taken out of their custody at any time *except* under court order.

To avoid substantial wasted administrative or professional time with the examination and copying of records relating to illnesses which do not fall within the inquiry of the patient, it is strongly urged that the administrator or physician request

NOTE

Chapter 301, Laws of 1959 created subsections (3) and (4) of Section 269.57, Wisconsin Statutes. Changes have been made in 1961 and 1963. The subsections now read as follows:

"(3) No evidence obtained by an adverse party by a court-ordered physical examination or inspection under sub. (2) shall be admitted upon the trial or by reference or otherwise unless true copies of all reports, photographs, records, papers and writings made as a result of such examination or inspection and received by such adverse party have been delivered to the party claiming damages or his attorney not later than 15 days after the said reports, photographs, records, papers or writings from any such court-ordered physical examination are received by the said adverse party, provided that in an action for recovery of personal injuries, the party claiming damages shall in return deliver to the adverse party against whom the action is brought a true and correct copy of all reports of each physician who has examined or treated such person with respect to the injuries for which damages are claimed.

"(4) Upon receipt of written authorization and consent signed by a person who has been the subject of medical care or treatment, or in case of the death of such person signed by his personal representative or by the beneficiary of an insurance policy on his life, the physician, surgeon or other person having custody of any medical or hospital reports, photographs, records, papers and writings concerning such care or treatment, shall forthwith permit the person designated in such authorization to inspect and copy such records. Any person having the custody of such records who refuses to comply with such authorization shall be liable to the person receiving such medical care and treatment for all reasonable and necessary costs of obtaining such copies and inspection and for attorney's fees not to exceed $50 plus costs.

"(5) The provisions of sub. (4) shall not be applicable to state or county mental hospitals, or to state colony and training schools, or to community mental health clinics established pursuant to s. 51.36."

CONSENT TO EXAMINATION OF PHYSICIAN'S RECORDS

To Dr. _____

I hereby authorize and request you to furnish a copy of the medical records of _____

_____, covering the period from _____ 19____ to
(State name of patient or "myself")

_____ 19____ or to allow those records to be inspected or copied by ____

_____. I hereby release you from all legal responsibility or liability that may arise from the act I have authorized above.

Signed _____

Witness _____ Date _____

CONSENT TO ACCESS TO HOSPITAL RECORDS

o _____, Hospital Administrator, _____ Hospital.

I hereby authorize you to furnish a copy of the hospital records of _____

_____, covering the period from _____ 19____ to
(State name of patient or "myself")

_____ 19____ or to allow those records to be inspected or copied by _____

_____. I hereby release _____ Hospital and you personally from all legal responsibility or liability that may arise from the act I have authorized above.

Signed _____

Witness _____ Date _____

that the illness and the period of time both be specified in the written authorization, or be agreed to by the person presenting such consent.

2. One of the results of the increasingly comprehensive services of the modern hospital, especially teaching institutions, is the development and maintenance of *two* types of records relating to a patient. One relates directly to his care and treatment, and is the direct professional reponsibility of the attending physician and of those acting under him. The other has sometimes been described as "educational records," which are typically made by nonmedical personnel as part of their training, or at least for purposes not directly related to the "medical care and treatment" of the particular patient.

It is believed that no record other than that made or approved by the physician in charge, or by a consultant, or resident, or by a registered nurse who is recording her acts or observations made pursuant to special or standing orders, is one which relates to the "medical care or treatment" of the patient, as that phrase is used in the new statute.

Consistent with the above conclusion, it is believed (1) the notes of the attending physician, consultants, and of a resident, plus (2) the patient's chart, are *all* that make up the official hospital record. X-rays have been treated earlier in recommendation 1 herein. Any *other* writings should be kept *separately* but *not* as a part of the patient's official record, for the reason that the persons making such writings are not professionally responsible for the patient, or are not licensed to practice medicine, and are not recording acts or observations made pursuant to orders of the attending physician. Such writings are not authentic records relating to the care or treatment of the patient.

There has been understandable apprehension on the part of some hospital administrators and physicians that the production for inspection or copying of nurses' notes, or of comments by interns, social workers, and others, could embarrass or damage the interests of the patient, the hospital, or the attending physician. It is emphatically recommended that medical staffs and hospital administrators embark on an immediate, intensive, and continuing program of education which has as its sole purpose the maintenance of patient records which are limited to physical findings, diagnosis, treatment, prognosis, and to acts or observations made in the course thereof, or made pursuant to standing or special orders. If medical staffs, nursing staffs, and personnel under training, will so limit what they write, whether as part of the official patient record, or as part of an educational record, such apprehensions will disappear.

Again, emphasis should be placed on the importance of *physically separating* writings relating to a patient into (1) those made by or under the authority of the attending physician, consultant, or resident, and (2) those made for educational, training, internal, or other collateral purposes. The two categories of writings should be *separated* when the patient is *discharged* from the hospital, since only the first of them relates to the "medical care or treatment" of the patient, and is the only type of record called for by the new statute, and the only type which the physician or hospital should present for inspection or copying.

3. If an authorized person demands more than the above, it should be *refused* and a court allowed to rule on the request. If hospital administrators, physicians, and interested members of the public cannot determine what is embraced in the phrase "medical or hospital reports" relating to the "care or treatment" of the patient, a judicial determination of this question may well become necessary and even desirable.

4. It is further believed that the authorization to inspect and to copy is *personal* to the patient, and for that reason *does not survive* his death. Thus an authorization signed by an executor, administrator or member of a deceased patient's family has no legal effect under subsection (4) of the statute.

5. The potential liability of a hospital for defamation, and the statutory liability of the physician for "wilful disclosure" of professional secrets, deserve brief comment. Both are under the primary duty of not permitting the operation of the statute to be broader than its wording.

Section 269.57 (4) does *not* in words or by implication, give a right to remove any records from the hospital, institution, or a physician's office, the records being the property of the hospital, institution or physician.

As an act of prudence, the hospital or physician should require that inspection and copying be carried on in the presence of a custodian (hospital or physician), or the representative of either. The statute does not require a hospital, institution, or physician to copy any records at the request of a patient or his representative. If a request is made by a patient or his representative, and the request is granted, the hospital, institution, or physician making such copy is entitled to make a reasonable and realistic charge for doing so.

As a precautionary measure to hospital administrative personnel and to physicians, it is suggested that under no circumstances should copies of any medical or hospital reports, which are prepared by a representative of the patient, be signed, initialed or subscribed to in any manner that may indicate authenticity and accuracy of such copies.

6. Few people, other than medically trained personnel, will know what is important in a hospital or medical record. For that reason a hospital librarian or other authorized person, or a physician, may in some situations be able to satisfy a request by making inquiry as to what the patient or his representative really wants from the records, and reading the material relative to the inquiry. This

may save a great deal of examining, copying, and inconvenience to everyone concerned.

7. The word "forthwith" used in connection with the right to inspect and copy records does *not* mean "immediately," but "as soon as the convenience of an administrator, a record librarian, or a physician, *reasonably* permits," after taking into account the urgency of prior demands on their time and personnel, and whether advance notice had been given of the demand of the particular patient.

8. When there is any indication that legal proceedings may ensue, the hospital, institution or physician served with a proper demand to examine or copy a patient's records should promptly notify its insurance carrier of this fact, and also the general attorney of the hospital, institution or physician. It is recommended that, in the interest of the patient, the hospital, and the physician, the knowledge of any such demand be given by the person receiving same to the other interested parties.

WISCONSIN'S HEALTH by E. H. JORRIS, M.D., State Health Officer

NURSING HOME CARE STARTED UNDER MEDICARE JANUARY 1

On January 1 some Wisconsin nursing homes started receiving patients under the Medicare program. January 1 marks the start of the only part of the program not previously put into operation. Nursing home care has been available under Medicaid since last July 1.

Medicare is available only in skilled nursing homes certified by the Social Security Administration upon recommendation of the State Board of Health. Certification is dependent on the facility meeting conditions which will assure patients of receiving high quality post-hospital care.

Many nursing homes have not been able to qualify for participation in the program because they are primarily engaged in providing custodial and personal care and such care is not covered by the program.

This new part of the Medicare program provides payment for nursing home care of up to 100 days for each spell of illness, if a physician certifies as to the medical necessity. The law further provides that the beneficiary must have been a patient in a participating hospital for three days prior to admission then must be admitted to the extended care facility within 14 days after hospital discharge.

In addition to surveying nursing homes and making recommendations for their certification, the State Board of Health offers consultations to help skilled nursing homes meet the conditions of participation and to qualify as providers of extended care services.

These services are primarily carried out by the Division of Medicare Services, under the direction of Mr. Louis Remily, and by the Division of Hospital and Related Services, under the direction of Mr. Vincent Otis.

A series of statewide conferences, which was started last August, prepared those involved for participation in the program. Program details were explained by a coordinating committee composed of representatives of the Wisconsin State Board of Health, Wisconsin Hospital Association, State Medical Society of Wisconsin, Blue Cross Plan, Wisconsin Council of Homes and Hospitals, Wisconsin Association of Nursing Homes, Association of Wisconsin County Homes, and Mutual of Omaha Insurance Company.

Following these meetings applications were mailed to 440 potential applicants. Of that number 107, with 8,108 beds, have, on December 28, 1966, been recommended for certification for participation in the program.

DIRECTORY AIDS CHOICE OF NURSING HOME

How does one select a nursing home?

Here in Wisconsin, where the proportion of elderly persons is somewhat higher than the average for the nation, more than 2,000 families each year must find a nursing home or other haven for some person, usually a relative. The average daily census of residents of nursing homes has grown from 10,704 in 1960 to 18,347 during 1965. From 1964 to 1965, for instance, the number of residents shot upward from 16,140 to 18,347—a total increase of 2,207!

A major help to persons who seek information is the annual directory of nursing homes and homes for the aged that are licensed by the Division of Hospital and Related Services of the State Board of Health. The current directory, which was mailed the latter part of October, 1966, lists a total of 506 licensed homes.

Copies of the new directory have been sent to every newspaper in the state, to every public health nursing department, to all hospitals, and to others. Persons who are unable to consult a directory in their own community may receive a copy on request to the Division of Hospital and Related Services, Wisconsin State Board of Health, Box 309, Madison 53701.

Legal Responsibilities of the Physician-Patient-Hospital Relationship

THREE SPECIFIC questions pertaining to the physician-patient-hospital relationship were recently submitted to the Society's legal counsel by the Commission on Hospital Relations and Medical Education for an opinion. The questions and excerpts from the opinion of legal counsel are presented below.

1. Is there a special legal responsibility of a physician to his hospitalized patient?

There are no Wisconsin statutes which directly cover or govern the question set out above. The only statutes on hospitals relate to construction, safety, standards of maternity departments, and in the case of the Fee Splitting Statute forbid a hospital to employ a physician or to engage in a fee splitting arrangement with him.

In general terms, the courts have held that a physician has a legal responsibility to his hospitalized patient to furnish that degree of professional skill which is the standard of the medical community, and to give such professional attention to the patient as the case requires. A physician is not legally excused for inattention to one patient on the grounds that he was occupied with the needs of others.

A physician has a continuing responsibility to his hospitalized patient at least to the point where the latter is well enough to be discharged, or sooner leaves without the physician's authorization. A physician may be charged with abandonment for neglecting a patient who needs his care, whether during or after hospitalization. Once a physician has agreed to care for a particular patient, he must continue to do so until the patient no longer needs his professional services, and he may be legally liable for neglect of the patient, or for ceasing to care for him until another physician has replaced him, unless he has been clearly discharged by the patient before the relieving physician actually takes over.

While a hospital nurse or technician may technically be in the employ of the hospital, a physician may incur legal liability for permitting a nurse or technician to carry out his treatment orders or assist him when he knows or has reasonable cause to know that such person is unsuitable for such duties by reason of inadequate training, experience, judgment or personality defect.

The essence of negligence is the absence of the degree of care owed by one person to another. Legal liability results when negligence causes physical injury or monetary damage to the object of such negligence. The principles of law involved are few, but their application depends upon the facts of the case, frequently as evaluated by expert testimony, and as found by a jury or court.

2. What is the joint legal responsibility of the physician and hospital to a hospitalized patient?

The courts increasingly tend to distinguish the *administrative* negligence of a hospital from the *professional* or *medical* negligence of a physician. The first is concerned largely with the furnishing of safe and adequate facilities, equipment, food and related services and the carrying out of such routines as bathing or other general care. The other is concerned with professional treatment or care by the physician, or the carrying out of the orders of a physician by a nursing staff, technicians or others. A hospital is liable in general for *administrative* negligence, and a physician for *professional* negligence on the part of himself or an agent, where injury results.

It is also possible that both hospital and physician *could* be liable for concurrent or related acts of negligence which united to cause damage to a patient, or where the negligent acts of the one aggravated the injuries caused by the other party.

Where joint negligence has occurred, the patient may elect to sue the hospital, the physician, or both. If the patient prevails in court against the two, he may enforce his judgment wholly against the hospital or the physician as he may prefer. If there was in fact joint liability of hospital and physician but the patient enforced his judgment against the latter, the physician may then look to the hospital for recovery for such portion of the damages he has paid as represents the hospital's share of the total liability established by the litigation.

As a general proposition the hospital and physician have *separate* legal responsibility to the patient. The former is concerned primarily with safe and adequate facilities and the exercise of a due standard of care in the selection and supervision of its staff. The physician is concerned with the professional care which he either renders or directs on behalf of the patient. While the decisions of various courts furnish numerous instances of suits in which hospital, physician and nurse were jointly sued, it is not uncommon for a court or jury to

determine during the course of the trial that no liability exists against one or more of the parties sued. In some cases only the hospital, or the physician or the nurse is found to have been liable in a particular situation. In other cases two of them may be found negligent. In still other cases the suit is dismissed as to all three.

While the functioning of the hospital as an institution and of its nurses and technical staffs with the medical staff call for a high degree of coordination, teamwork and close understanding, all for the benefit of the patient, such facts do *not* of themselves create a joint legal responsibility. Perhaps the best explanation is that while teamwork and cooperation are *practical necessities* they do not automatically create a *joint legal responsibility*. It is up to the patient who asserts negligence to declare whether the hospital, as an administrative institution or as an employer, is responsible for his injury and damage, or whether the physician or others acting under his direction were primarily responsible.

It is therefore neither necessary nor advisable to try to generalize a joint responsibility since it is seldom present in fact.

3. What is the extent of legally enforceable rights of a physician against a hospital in which he has staff privileges?

The legally enforceable rights of a physician against a hospital growing out of his staff privileges are relatively limited in character. Thus a staff physician cannot demand that certain managerial policies be adopted, for that is the function of the governing board and its administrator. He cannot demand that the hospital purchase certain equipment, but is entitled to observe that such equipment as it has is inadequate, poorly maintained or unsafe. The latter right grows out of his concern for patient interest and his professional competence to make the observations.

There are two areas worthy of comment in which a staff physician has legally enforceable rights. The first is exemplified in the so-called "inhospital staff specialties" such as radiology, pathology and physiatry. When the medical staff and the governing body of a hospital consider that it is in the public interest, it is lawful for practitioners in these specialties to contract with a hospital to provide consultation services for attending physicians. Such consultants must be members of or acceptable to the medical staff of such hospital. So long as a contract between such a specialist and a hospital relating to his practice is in accordance with the fee splitting statute and other applicable laws, it is enforceable by him against the hospital and by the hospital against him.

The second area of legally enforceable rights enjoyed by staff physicians are those which relate to staff privileges as such. The documents which govern staff privileges are typically bylaws, rules and regulations, the application of an individual physician for staff privileges and the official action on such application, first, by the medical staff, and then by the governing body of the hospital. A physician whose staff appointment is regular in every respect acquires legally enforceable rights once he becomes a member of the medical staff. Those rights depend upon and are limited by the provisions of the hospital bylaws, rules and regulations, and by any particular conditions attached to his appointment, such as limitations on surgical privileges.

It is the proper business of the individual and collective membership of a medical staff to see that the granting of staff privileges, their limitation, suspension and termination are spelled out clearly, adequately and fairly. This is a matter of proper concern to patients whom the physician may hospitalize, and of enlightened self-interest to physician and hospital as well.

There appears to be a trend generally in the courts of this country to recognize something akin to a property right in hospital staff privileges *once they are granted*, so long as they remain in force, and assuming that the physician is not guilty of acts of professional negligence or misconduct. This means that the trend of the courts is away from permitting summary suspension or termination of staff privileges without a fair hearing, except for grave cause which might endanger patients or create liability on the part of the hospital.

In my judgment increasing importance should be attached to "negotiations" between the medical staff and the governing body or administrator of a hospital. These can be conducted by the Chief of Staff of a very small hospital, or by the Executive Committee of the medical staff of a larger hospital, in areas in which patient welfare and safety are involved, or in which tensions or conflict may arise between hospital policy and medical policy to the detriment of patient welfare. The latter are not matters of contract right as such, but are akin to "collective bargaining", and become a matter of understanding at the point the hospital and the medical staff are in agreement. They might include such areas as the unwillingness of the governing body of the hospital to follow medical staff recommendations for granting or limiting staff privileges; failure to purchase desirable or needed equipment or to replace equipment in the interests of patient safety or welfare; inadequate selection of the nursing, technical and other staffs of the hospital, or insufficient supervision and continued training during the course of employment.

While we find no Wisconsin cases on the point, a physician undoubtedly could, as we earlier indicated, enforce a right of contribution against the hospital in a situation in which he had been held liable and a judgment enforced against him, although the liability was partially that of the hospital.

* * *

Many points have not been covered in this opinion because they did not seem closely enough related to the questions. Thus, there has been no discussion of the contractual relationship between patient and

physician. Rather it has been assumed to exist for purposes of answering the questions. No questions of adequacy of patient consent, either from the standpoint of physician or hospital, have been touched upon. It has been assumed also that hospital records were adequately maintained by the physician and by the non-medical staff under his direction, and that in other respects not specified the hospital and its employees were functioning properly and the physician was acting within the limits of the standard of professional care owed the patient.

MALPRACTICE DEFINED

MALPRACTICE . . . Section 147.22 of the Wisconsin Statutes, quoted below, is concerned with the legal consequences to those who "treat the sick" without or beyond the limits of a license or certificate of registration. One such consequence is full liability for the penalties of malpractice even where it is the result of ignorance rather than negligence or lack of skill. The wording covers failure to perform or attempt to perform as well as actual performance.

The statute has application to such persons as chiropractors, podiatrists, or optometrists when they exceed their respective limited licenses or certificates.

Section 147.22 reads as follows:

> "Anyone practicing medicine, surgery, osteopathy, or any other form or system of treating the afflicted without having a license or a certificate of registration authorizing him so to do, shall be liable to the penalties and liabilities for malpractice; and ignorance on his part shall not lessen such liability for failing to perform or for negligently or unskillfully performing or attempting to perform any duty assumed, and which is ordinarily performed by authorized practitioners."

NARCOTICS

Annual Registration

You must register with and pay tax to the District Director for the Internal Revenue District in which you propose to engage in any activity involving the use of narcotic drugs. For Wisconsin, the correct address is District Director, Internal Revenue Service, Post Office Building, Room 296, Milwaukee, Wisconsin 53202.

Change of Residence

Do not fail to notify the District Director, Milwaukee, Wisconsin, of any change of address. Failure to notify him will make you subject to penalties.

In Case of Death

The District Supervisor, Bureau of Narcotics, Chicago, Illinois, whose jurisdiction encompasses the State of Wisconsin, has notified the State Medical Society that the following conforms with current Federal Regulations:

> "The deceased physician's Tax Stamp, unused government order forms and narcotic drugs should be disposed of as soon as possible. The Special Tax Stamp and unused government order forms (Form 2513) should be returned to the District Director, Internal Revenue Service, Post Office Building, Milwaukee, Wisconsin 53202. The narcotic drugs may be disposed of by shipment, charges prepaid (shipment by registered mail is permissible) to the District Supervisor, Federal Bureau of Narcotics, 1836 U. S. Courthouse and Federal Office Building, Chicago, Illinois 60604, after the drugs have been inventoried on Forms 142, copies of which can be obtained from the District Supervisor. One copy of the Form 142 will be returned to the sender upon receipt of the narcotic drugs. No remunerations will be made for the narcotics surrendered to the Bureau of Narcotics."

Preprinted Prescription Blanks

The Treasury Department, Federal Bureau of Narcotics, reports that neither Federal law nor administrative regulations prohibits the printing of the physician's narcotic registration number on prescription blanks.

Problems of a Physician's Widow

FOLLOWING the loss of one of its members by death, it has long been the practice of the State Medical Society to write the physician's widow in an effort to provide some advice during a trying period. The Society, believing that "an ounce of protection is worth a pound of cure," suggests that every member give thoughtful consideration to some of the problems which are likely to face a physician's widow. Careful preparation for such eventualities not only protects the family, but eases its burdens at a trying time.

Following the death of a physician, the widow will be faced with many decisions involving the settlement of the business affairs relating to her late husband's practice. It is of extreme importance that she act upon the advice of an attorney. When practical it is recommended that the physician acquaint his wife with his legal and other advisors and some of his business affairs. This will provide an established working business relationship between the wife and the advisors for that eventuality when she is called upon to act. Some of the chief problem areas the widow will face are outlined in the remainder of this article.

Former patients may seek a continuation of medication prescribed by the deceased physician. This must never be permitted except on advice of another physician because of the possibility of rapid change in the condition of the patient and resultant possible cause for legal action in the event unexpected results stemmed from continued use of the medication.

The widow will also be presented with the problem of what to do with the physician's narcotics. The District Supervisor, Federal Bureau of Narcotics, Chicago, Illinois, approved the following procedure in a recent communication to the State Medical Society:

> "The deceased physician's Tax Stamp, unused government order forms and narcotic drugs should be disposed of as soon as possible. The Special Tax Stamp and unused government order forms (Form 2513) should be returned to the District Director, Internal Revenue Service, Post Office Building, Milwaukee, Wisconsin 53202. The narcotic drugs may be disposed of by shipment, charges prepaid (shipment by registered mail is permissible) to the District Supervisor, Federal Bureau of Narcotics, 1836 U. S. Courthouse and Federal Office Building, Chicago, Illinois, 60604, after the drugs have been inventoried on Forms 142, copies of which can be obtained from the District Supervisor. One copy of the Form 142 will be returned to the sender upon receipt of the narcotic drugs. No remunerations will be made for the narcotics surrendered to the Bureau of Narcotics."

It is important that a widow, other members of the family and the attorney see to it that there is full and prompt compliance with the requirements of the above communication.

Instructions on the disposal of non-narcotic drugs in the possession of the physician at the time of his death may be obtained from the State Board of Pharmacy, State Office Building, Milwaukee.

Records relating to patients, including case histories, treatment records, x-rays, laboratory reports, correspondence with physicians and others should *not* be destroyed for at least six years after the physician's death. Liability for malpractice and some other claims do not cease upon the death of a physician.

The physician's records and liability insurance policies may be the widow's chief sources of defense. Every precaution should be taken to insure that all such basic materials are kept intact and subject to immediate call for at least six years. The family attorney will be able to tell when they are no longer needed for this purpose.

The widow can expect that the deceased physician's patients will seek care elsewhere unless he had one or more associates. Sometimes the new physician will find it necessary for adequate treatment to obtain a copy of the previous physician's record of care of his patient. In such event, it is wise to insist upon a written request from the patient and his new physician. A copy of the record, with a covering letter may then be sent. A copy of the forwarding letter should be inserted in the original patient's file for future reference.

A decision may be made to sell the deceased physician's practice. The items to be included in the sale will vary with the nature of the practice, the amount of equipment involved and the wishes of the buyer.

To avoid complications, the widow should make sure the buyer is a physician licensed in Wisconsin. This information can be obtained from physician acquaintances or the State Medical Society. Records relating to patients should *not* be sold. However, the sale may include, as one of its terms, unlimited access to the records of those patients who seek the services of the purchasing physician. The widow's legal and other advisors can best inform her how to arrange the sale.

The collection of the deceased physician's professional accounts is another important matter. She should carefully follow her attorney's advice before bringing suit, since a patient can counterclaim for malpractice within three years. Ordinarily it is not desirable for a widow or the heirs to enforce collection by suit within such period. She should also seek legal and accounting advice on how long to retain the financial records of her late husband. It is quite possible that his estate may be subjected to audit by the state or federal income tax authorities. The retention of complete records is essential in anticipating such possibility.

The State Medical Society office is always available for consultation with a widow, her family or the estate attorney.

Physicians' Guidelines for Delegation of Duties and Functions to Nurses

THE SOCIETY has been asked on a number of occasions whether a certain procedure could be performed by a nurse. Following are some guidelines for a physician to follow when he considers delegating some function, procedure or duty to a nurse.

Three general principles control delegation to nurses. They are:

1. A physician can lawfully delegate to nurses only those functions, procedures or duties which do not require the exercise of his professional judgment.
2. The nurse must have training and experience in the function, procedure or duty to be delegated by the physician.
3. All such functions, procedures or duties must be performed under the direction or supervision or upon the prescription of a physician.

The "practice of medicine" has been described as the primary professional responsibility of the physician for the total care of his patient. Under Wisconsin law a physician is granted an unlimited license. This is legislative recognition of his comprehensive training and his corresponding professional responsibility. Nurses are not granted such a license nor are they trained for such an overall responsibility. It should not be necessary to reiterate that a nurse cannot "practice medicine", or that a physician cannot, except in a genuine emergency, lawfully delegate the power to practice medicine to her wittingly or unwittingly. This is true even though the nurse is willing to perform a function that requires the exercise of the professional judgment of a physician.

The late Louis J. Regan, who was both a doctor of medicine and an attorney, speaking of industrial nursing, sums up the delegation question in the following words:

> "Authority to diagnose, treat, operate or prescribe cannot be delegated."
>
> LOUIS J. REGAN, *Doctor and Patient and the Law*, 3rd Ed., p. 484

Doctor Regan's text also contains the statement on page 483 that a nurse "should assume no responsibility for service outside the field of her professional training." A professional nurse's training is comprehensive in the field of nursing, but it does not encompass training for the practice of medicine. A nurse who is not trained in a procedure and does not have experience in it should not be allowed to perform it. Professional liability for her acts could attach to the physician who ordered a nurse to perform a procedure beyond her competence.

The training of nurses is divided into two levels. The longer and more comprehensive training leads to professional nursing and the lesser to practical nursing. These are separately defined in the Wisconsin Statutes. Section 149.10(1) of the Wisconsin Statutes defines "professional nursing", and Section 149.10(2) defines "practical nursing". These definitions are as follows:

> "149.10 Definitions. (1) Practice of Professional Nursing. The practice of professional nursing within the terms of this chapter means the performance for compensation of any act in the observation or care of the ill, injured or infirm, or for the maintenance of health or prevention of illness of others, which act requires substantial nursing skill, knowledge or training, or application of nursing principles based on biological, physical and social sciences, such as the supervision of a patient, the observation and recording of symptoms and reactions, the execution of procedures and techniques in the treatment of the sick *under the general or special supervision or direction of a physician*, the execution of general nursing procedures and techniques and the supervision and direction of trained practical nurses and less skilled assistants."
>
> "(2) Practice of Practical Nursing. The practice of practical nursing under this chapter means the performance for compensation of any simple acts in the care of convalescent, subacutely or chronically ill, injured or infirm persons, *or of any act or procedure in the care of the more acutely ill, injured or infirm under the specific direction of a nurse or physician.* A simple act is one which does not require any substantial nursing skill, knowledge or training, or the application of nursing principles based on biological, physical or social sciences, or the understanding of cause and effect in such acts and is one which is of a nature of those approved by the board for the curriculum of schools for trained practical nurses." (Italics supplied)

Note that in the definition of professional nursing a nurse can treat the sick only "under the general or special supervision or direction of a physician."

Similarly, attention should be given to the italicized wording in subsection (2), quoted above. It says, when read with the first part of the sentence, that "practical nursing" means *not only* simple acts in the care of convalescent and other specified persons, but also "*any act* or *procedure* in the care of the more acutely ill, injured or infirm under the *specific* direction of a [professional] nurse or physician."

The reasonable meaning of the above is that a practical nurse is not limited by statute to what

is described in the first part of subsection (2). A trained practical nurse may *also* perform any act or procedure in the care of the more acutely ill, injured or infirm, *provided* she does so under the specific direction of (a) a professional nurse, or (b) a physician.

Some common sense considerations need to be observed, however. First, neither a physician nor a professional nurse can *lawfully* delegate to a trained practical nurse an act or procedure which would be legally improper for the professional nurse. Second, the phrase "specific direction" reasonably means *in the presence* and under the *immediate supervision* of the physician or professional nurse. This provides the safeguards indicated by the more limited training, skill and experience of the practical nurse.

However, neither type of nurse is authorized by the statutes to diagnose, operate or prescribe. Even the professional nurse can treat the sick *only* under physician supervision or direction.

Supervision or direction of a professional nurse by a physician can take many forms. Physical presence of the physician is not necessarily required in all instances. Many things are done upon the prescription of the physician. In this sense the prescription of a physician means a written order of a physician. This can be either a prescription as used in its normal meaning or an order written in the hospital or other charts.

In the last analysis, the matter becomes one of common sense of the physician, supplemented and guided by his professional training and experience and, equally important, by medical ethics and tradition.

ABORTION Protect Yourself

THE WISCONSIN Criminal Code provides a fine up to $5,000.00 or imprisonment up to three years or both for the intentional destruction of the life of an unborn child. The law states that an "unborn child" means a human being from the time of conception until it is born alive. If the life destroyed is that of an "unborn quick child" or of the mother, the imprisonment may be as high as 15 years.

A therapeutic abortion is exempt from these penalties, but only when three specific conditions have been met:

1. The abortion must be performed by a physician.
2. At least two other physicians must advise that the abortion is, or appears to be, necessary to save the life of the mother. Therapeutic necessity must be based on danger to the mother's life, not simply on danger to her health. In an emergency the physician is permitted by statute to perform an abortion without the advice of two physicians, but he must be able to prove that the abortion was necessary to save the life of the mother.
3. The abortion must be performed in a licensed maternity hospital, except where emergency prevents.

If you are called upon to treat a woman who has had an attempted or completed abortion:

1. Insist on the presence of at least one other physician (not an associate) before treatment is given, or
2. When no other physician is available, insist on a written statement from the patient, in the presence of witnesses if possible, reciting the facts concerning the performance of the abortion and including the name of the abortionist. The necessary treatment should then be given only after the patient understands that the physician may use the statement in the event he later requires it for his own protection.

The above two steps are recognized by the Wisconsin Supreme Court as reasonable precautions before treating a woman who has had an attempted or completed abortion.

Abortion Deaths To Be Reported

Sometimes forgotten is the statutory requirement that all physicians must immediately report knowledge of any death following an abortion. The report must be made to the sheriff, police officer, or coroner of the county in which the death occurs.

Legal counsel for the Society believes the reporting requirement is intended to apply only to those situations in which the mother dies following an abortion and not to the destruction of a fetus. Pending clarification of this point by the legislature or the courts, the physician will do well to report *all* deaths associated with abortion.

REFERENCES

1. Wisconsin Statutes, 1965, Section 940.04
2. Wisconsin Statutes, 1965, Section 966.20
3. *State v. Law* (1912) 150 Wis. 313

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Guide for Athletic Disqualification

Junior and Senior High School Level

(This guide applies particularly to football, basketball, wrestling, hockey and baseball; however, there are aspects which will be of value to physicians in determining disqualification in other sports.)

A PHYSICIAN examining junior and senior high school athletes must use good judgment in deciding whether or not to restrict a boy from competition. The purpose of this presentation is to summarize some of the important factors to help physicians arrive at a logical conclusion so that a boy is not unnecessarily prohibited from competing nor allowed to compete when he should be disqualified.

There are two major considerations for restricting persons from participation in athletics:

(1) Is there a disease or process which prevents the individual from competing fairly with normal persons?

(2) Is there a disease or process which might be aggravated by athletic competition?

Both of these are relative and circumstances alter decisions.

Conditions considered disqualifying:

(1) *Maturity*—the physician must keep this in mind when examining the athlete. The state of maturity varies greatly in adolescents of the same age. Almost all boys have reached the same stage of maturity by the junior year in high school, but many freshmen and some sophomores are not mature and should be withheld from competing with boys who are. At earlier levels, seventh and eighth grades, it is important to spot the boy who is mature and prevent him from injuring his classmates in pre-high school activities. The large boy is not always the mature boy.

Clinical judgment of maturity can best be based on the presence and degree of secondary sex characteristics—deep voice, acne, facial and body hair, axillary and pubic hair and the appearance of the external genitalia. The most helpful sign in evaluating the attainment of full sexual maturity is finding that the pubic hair has extended to the inner thighs.

(2) *Absence or Severe Disease of One of a Paired Organ*—this is an absolute contraindication for participation when it involves the eye, ear, kidney, testicle, or lung. Some may argue that the incidence of injury to these organs is small, but the obvious serious sequela, should one occur, makes this decision an easy one.

(3) *Disease of the Cardiovascular System*—here is one of the two areas of greatest uncertainty for physicians who examine athletes. There is a tendency to be over cautious. Many youngsters are denied athletic participation because of a functional heart murmur. Heart murmurs are not necessarily abnormal. The presence of a murmur is not in itself an indication to deny participation in sports. The youth with a heart murmur should have a thorough investigation to determine the reason for the murmur.

The presence of organic heart disease, especially rheumatic or congenital heart disease, is a reason for disqualification from contact sports. Those who have mitral stenosis or aortic stenosis may be seriously harmed by severe exertion. Those with cyanotic congenital heart disease ordinarily limit their activity of their own accord, but they are not competent in athletics because of their short span of endurance.

A history of rheumatic fever does not necessarily disqualify an individual for competition.

Cardiac arrhythmia, not associated with organic heart disease, is not disqualifying.

Hypertension, usually defined as persistent systolic pressure over 140 mm Hg. or diastolic pressure above 90 mm Hg., should be evaluated by repeated examinations. It is not unusual to find many high school athletes with excessive blood pressure on an emotional basis. If it does not drop readily, further evaluation is necessary to rule out coarctation of aorta, unilateral kidney disease, or some other congenital abnormality.

Also disqualifying for contact sports is peripheral vascular disease.

(4) *Hernia and Hydrocele*—disqualifying until repaired.

(5) *Nervous System*—it is not justified to allow a boy to compete in contact sports if he has had three or more periods of unconsciousness. There is a high percentage of deaths in athletes from head injuries and most of these had a previous injury before the fatal one.

(6) *Orthopedic Conditions*—this is the second area of uncertainty.

Epiphyseal diseases such as Osgood-Schlatter disease, Legg-Perthes disease, and other related osteochondroses do occur, and athletic competition should be limited while the lesions are painful.

Back pain is rare in high school athletes. Any boy who has persistent back pain should be x-rayed and closely evaluated for some congenital abnormality

Prepared by the Division on School Health of the State Medical Society of Wisconsin and approved by the Commission on State Departments Nov. 15, 1964, and by the Council, Dec. 12, 1964.

or early rheumatoid spondylitis. Congenital spondylolisthesis and Scheuermann's disease are some examples as causes of back pain and should be considered for at least temporary disqualification for contact sports. This is a physician's decision.

Some frequent abnormalities encountered are pes planus, genu valgum, genu varum, scoliosis and leg length inequality. Each of these may be mild and cause no concern. On the other hand, each of these may be of marked degree and be clinically symptomatic. If this is the case, athletic competition should be restricted. The physician must decide.

(7) *Epilepsy and Diabetes*—when under control they are not causes for restriction from athletics.

The physician must exercise careful judgment in making his decisions about participation of an individual in athletics. His decision must be based on accurate diagnosis of the condition, on reasonable knowledge of the disease process, on intimate knowledge of the many types of sports and the physical needs of each, and on his evaluation of the person. If the physician is not aware of these considerations which affect his decision, then his decision may be harmful to the athlete, to the team and to himself.

SALE OF CONTRACEPTIVES AND ABORTIFACIENTS

Only licensed physicians and registered pharmacists may sell contraceptives and abortifacients or articles appropriate to that use and sold with the intention that they be so used. In no event may such article, drug or preparation be sold to any unmarried person.

Prohibited also is the advertising or public display of such articles for sale, or the manufacture, purchase or possession of a machine or device appropriate for vending contraceptives or abortifacients.

Violation of the provisions of this statute subjects the violator to a fine of one hundred dollars to five hundred dollars ($100 to $500), or imprisonment in a county jail not to exceed six months, or both.

Reference: Section 151.15, Wisconsin Statutes, 1965.

LET THESE GUIDES HELP YOU

The following guides and manuals have been prepared at the direction of a number of councils, commissions, divisions, and committees of the State Medical Society to be of direct personal assistance to the physician or his county society. Each is available without cost upon request to the State Medical Society office, Box 1109, Madison, Wisconsin 53701.

Interprofessional Code

An instrument for better understanding between attorneys and physicians with reference to medical testimony and interprofessional conduct and practices.

Guide to The Service Corporation Law

A series of questions and answers describing Chapter 350, Laws of Wisconsin, 1961, allowing physicians, among others, to form private medical corporations for the tax benefit of their stockholders.

Code of Necropsy Procedure

A guide to physicians, hospitals, and funeral directors in the performance of necropsies.

Hearing Conservation Programs for Wisconsin Industries

Some recommended standards and principles for providing a hearing conservation program in industry.

Occupational Health, A Guide for Medical and Nursing Personnel

General principles and suggested plans for an industrial health program, with emphasis on written procedure for nurses.

New expanded edition—$5.00 with binding, $4.00 without binding. Ideal for any industrial plant with nurse service.

Find Your Future in the Health Field

A career guide (the health careers brochure).

Guide to Immunization Planning

An approved guide including recommended procedures for routine immunizations, parental responsibility, physician responsibility, medical society responsibility and steps for successful community planning.

Inspection of Medical Records

An interpretation of Chapter 301, Laws of 1959 relating to the right of access to physician and hospital records concerning patient care. Sample consent forms are included.

Principles for Transporting the Ill and Injured

A guide for providing emergency transportation services, including model community and state ordinances.

School Vision Screening Program

An outline to facilitate the development of a program to detect significant visual defects among school children.

First Aid Chart

Guide to Interpretation of Chapter 484, Laws of Wisconsin, 1959

Relating to fee splitting between physicians and others.

Your Deadlines and Other "Musts"

Below are some of the deadlines and "musts" of a practicing physician:

TAXES

1. By January 15, 1967, you must pay the final installment of the estimated federal and Wisconsin tax on your 1966 income. This may necessitate an amended declaration by that date if you find that you underestimated 1966 income. A final income ta xreturn for 1966, filed on or before January 31, 1967, accompanied by payment in full of the amount computed on the return as payable, will be treated as an amended declaration as of January 15 for both Wisconsin and federal purposes. Penalties are assessed for certain underestimating of taxes. These penalties and their avoidance are discussed in Section 6 below.

2. By January 31, you must:
   (1) File the employer's return of income taxes withheld in 1966 on Forms W-3 (Federal) and WT-7 (Wisconsin). These are summary report forms for the Forms W-2 (Federal) and WT-9 (Wisconsin), respectively.
   (2) Furnish a statement to employees on Forms W-2 (Federal) and WT-9 (Wisconsin) showing wages paid and amount of tax withheld during the calendar year 1966.
   (3) File fourth quarterly return for 1966 of income and Social Security taxes withheld on wages paid employees on Form 941 (Federal) and, for income taxes withheld on wages only, on Form WT-6 (Wisconsin).
   (4) Furnish a statement to payees to whom interest, rent, compensation not reported on Form W-2 (Federal) and similar types of payments have been paid on Form 1099 (Federal).
   (5) File annual federal unemployment tax return on Form 940 (Federal).

3. By February 28, you must file a summary report on Form 1096 (Federal) attaching copies of the Forms 1099 (Federal) furnished to payees.

4. By April 15, you must:
   (1) File your personal income tax returns on Forms 1040 (Federal) and Form 1 (Wisconsin).
   (2) If a partnership, file your partnership income tax return on Forms 1065 (Federal) and 3 (Wisconsin).
   (3) File and furnish a copy to payees to whom interest, rent, compensation not reported on Forms WT-9 (Wisconsin) and similar types of payments have been paid on Form 9b (Wisconsin).

5. During 1967, you must:
   (1) File quarterly returns by April 30, July 31, and October 31 of income and Social Security taxes withheld on wages paid employees on Form 941 (Federal) and, for income taxes withheld on wages only, on Form WT-6 (Wisconsin).
   (2) File quarterly Wisconsin employer's unemployment compensation reports by the dates stated on the Form UC-101 furnished quarterly by the Industrial Commission.

6. Estimates of Income; Quarterly Adjustments; Penalties.

   The first quarterly estimate of your 1967 income must be shown on Wisconsin and federal declaration forms which have to be filed, together with the estimated tax then due, by April 15, 1967. Other installments of the tax are due, together with amendments in the declaration should there be a change upward or downward, by June 15, and September 15, 1967. As to the final installment due in January, 1968, follow the alternative procedure described in Section 1, above.

   Excluding cases of willful understatement, a penalty is provided for underpaying taxes on declarations of estimated income. This penalty is a 6 percent assessment computed for each installment date on the difference between the amount paid and 80 percent of the amount which should have been paid. The penalty can be avoided if your quarterly installment payments meet one of four exception provisions following. (1) You may pay an amount at least equal to the tax shown on your return for the preceding taxable year. (2) Or, you may estimate your tax on the facts shown on your return for the preceding taxable year, but using current tax rates and personal exemptions. (3) Or, you may pay with each quarterly installment an amount at least equal to 80 percent of a tax then computed as if your income for the balance of the year remaining were to continue at the same rate. (4) Or, you may pay with each quarterly installment an amount at least equal to 90 percent of a tax computed at current rates on the actual taxable income for the months preceding each quarterly installment.

7. Comments on Preceding Information.

   The preceding tax information is general and not exhaustive. Alternate methods of fulfilling these tax requirements do exist. Different forms may be required. The forms and instructional sheets furnished with them should be consulted to determine appropriate alternate methods and forms to use.

The deadline dates apply to taxpayers who use the calendar year as their fiscal year.

Returns and filing dates for personal service corporations differ for certain of those discussed.

ANNUAL REGISTRATION IN WISCONSIN

Register with the Secretary of the Wisconsin State Board of Medical Examiners, 1414 South Park Street, Madison, Wisconsin 53715, in the month of January. This registration will be on a form furnished by the Board of Medical Examiners and should be accompanied by the registration fee shown on that form. Sec. 147.175, Wis. Statutes.

ANNUAL NARCOTICS REGISTRATION

1. Register with the District Director, Internal Revenue Service, Milwaukee, Wisconsin, as required by the federal narcotics law, and pay the annual tax of $1.00 *before* July 1, 1967. I.R.C. 1954, Sec. 4751 and 4753. You are subject to penalties for overlooking either the registration or the tax.
2. Notify the District Director, Internal Revenue Service, Milwaukee, Wisconsin, of changes in place or places of business to insure the legality of your narcotics license.

REMEMBER TO:

1. Make prompt report to the State Board of Health, State Office Building, 1 West Wilson Street, Madison, Wisconsin, 53702, of communicable diseases. Sec. 143.04, Wis. Statutes.
2. File with the city health officer or county register of deeds, as appropriate, a certificate for all births attended by you within five (5) days of the event. Otherwise your medical fees are unlawful. Sec. 69.30 (1), Wis. Statutes.
3. Register with the county judge if you desire reference work on commitment proceedings for persons alleged to be mentally ill, mentally infirm, mentally deficient, inebriate, or drug addicts.
4. Notify the next of kin or a person who may be chargeable with the funeral expenses before you send, or cause to be sent, the corpse of any deceased person to a funeral director, undertaker, mortician, or embalmer. The penalty is severe for failure to do so. Secs. 156.14; 156.15 (1), Wis. Statutes.
5. Report *immediately* the following deaths, as required by Sec. 966.20, Wis. Statutes, to the sheriff, police chief, or coroner of the county in which such death occurred:
   a. All deaths in which there are unexplained, unusual, or suspicious circumstances.
   b. All homicides.
   c. All suicides.
   d. All deaths following an abortion.
   e. All deaths due to poisoning, whether homicidal, suicidal or accidental.
   f. All deaths following accidents, whether the injury is or is not the primary cause of death.
   g. When there was no physician in attendance within 30 days preceding death.
   h. When a physician refuses to sign the death certificate.

1967 LEGISLATIVE DIRECTORY AVAILABLE

The 1967 Legislative Directory, which lists the name, political party, district represented and home address of each senator and assemblyman who will serve in the 1967 legislature, and includes senate and assembly maps showing names of the legislators representing those districts, is available from Wisconsin Taxpayers Alliance, 335 West Wilson Street, Madison, Wis. 53703. Prices: 1–49, 5 cents per copy; 50–99, 4 cents per copy; and 100 or more, 3 cents per copy.

POST MORTEM EXAMINATION

Question: Whose consent is required to permit a physician to conduct a post mortem examination?

Answer: Except for those cases in which an autopsy is ordered in connection with a proposed coroner's inquest, permission for a physician to conduct a post mortem examination requires the consent of the person who assumes custody of the body for burial, providing he is one of the following: father, mother, husband, wife, child, guardian, or next of kin.

If none of these is available, consent may be given by a friend or person charged by law with the responsibility for burial. If two or more such persons assume custody of the body, the consent of either one is sufficient.

Reference: Sections 155.05 and 966.121, Wisconsin Statutes, 1965.

Charter Law of Medical Societies in Wisconsin

Chapter 148

148.01 (1) State society. The state medical society of Wisconsin is continued with the general powers of a corporation. It may from time to time adopt, alter and enforce constitution, bylaws and regulations for admission and expulsion of members, election of officers, and management.

(2) A member expelled from a county medical society may appeal to the state society, whose decision shall be final.

148.02 (1) County societies. The physicians and surgeons, not less than five in number, of the several counties, except those wherein a county medical society exists may meet at such time and place at the county seat as a majority agree upon and organize a county medical society, and when so organized it shall be a body corporate by the name of the medical society of such county, shall have the general powers of a corporation, and may take by purchase or gift and hold real and personal property. County medical societies now existing are continued with the powers and privileges conferred by this chapter.

(2) Physicians and surgeons who, before April 20, 1897, received a diploma from an incorporated medical college or society of any of the United States or territories or of any foreign country, or who shall have received a license from the state board of medical examiners, shall be entitled to meet for organization or become members of the county medical society.

(3) If there be not a sufficient number of physicians and surgeons in any county to form a medical society they may associate with those of adjoining counties, and the physicians and surgeons of not more than fifteen adjoining counties may organize a medical society under this chapter, meeting at such time and place as a majority agree upon.

(4) A county medical society may from time to time adopt, alter and enforce constitution, by-laws and regulations for the admission and expulsion of members, election of officers, and management, not inconsistent with the constitution, bylaws and regulations of the state society.

148.03 (1) Nonprofit plans for sickness care. The state society, or a county society in manner approved by the state society, shall have the power to establish in the state or in any county or counties therein, a nonprofit plan or plans for the sickness care of indigents and low income groups, and others, through contracts with public officials, and with physicians and others, and by the use of contributions, cooperative funds, and other means, provided only that free choice of physicians within such contracts shall be retained and that responsibility of physicians to patient and all other contract and tort relationships with patient shall remain as though the dealings were direct between physician and patient. Any person covered by or insured under such plan shall be free to choose for sickness care any medical or osteopathic physician, licensed to practice in Wisconsin who has agreed to abide by such plan according to its terms and no such physician or osteopath shall be required to participate exclusively in any such plan.

(2) Such plans shall be governed by the provisions of s. 200.26 and by no other law relating to insurance unless such law is referred to in s. 200.26 and no law hereinafter enacted shall apply to such plans unless they are expressly designated therein or refer to such organizations as are responsible for the operation of such plans.

1841—THE SOCIETY CREATED BY TERRITORIAL LEGISLATION

The first statutory recognition of the State Medical Society was by act of the Legislative Assembly of the Territory of Wisconsin, in Act 53 of the Territorial Legislature of 1841. The organization of the Society was authorized, with the declaration that ". . . well regulated medical societies have been found to contribute to the advancement and diffusion of true science, and particularly of the healing art. . ."

The organization meeting was set for the second Monday in January, 1842, at Madison, for the purpose of forming ". . . a society under the name and style of the Medical Society of the Territory of Wisconsin. . ." Drs. Bushnell B. Cary, M. C. Darling, Lucius I. Barber, Oliver E. Strong, Edward McSherry, E. W. Wolcott, J. C. Mills, David Walker, Horace White, Jonas P. Russell, David Ward, Jesse S. Hewett, B. O. Miller, and their associates, were authorized by statute to conduct the initial organization of the Society.

Constitution and Bylaws of the State Medical Society of Wisconsin*

CONSTITUTION

ARTICLE I

NAME OF THE ASSOCIATION

The name and title of this organization shall be the State Medical Society of Wisconsin.

ARTICLE II

PURPOSE

The purposes of this Society shall be to federate and bring into one compact organization the entire medical profession of the State of Wisconsin, and to unite with similar societies of other states and territories of the United States to form the American Medical Association; to extend medical knowledge and advance medical science; to elevate the standard of medical education, and to secure the enactment and enforcement of just medical laws; to promote friendly intercourse among physicians; and to enlighten and direct public opinion in regard to the great problems of state medicine, so that the profession shall become more capable and honorable within itself, and more useful to the public, in the prevention and cure of disease, and in prolonging and adding comfort to life.

ARTICLE III

COMPONENT SOCIETIES

SECTION 1. Component societies shall consist of those county medical societies which hold charters from this Society.

SEC. 2. The terms, county medical society and component county medical society, shall be deemed to include all county medical societies and academies of medicine now in affiliation with this Society, or which may hereafter be organized and chartered by the House of Delegates of this Society.

ARTICLE IV

COMPOSITION OF THE ASSOCIATION

SECTION 1. This Society shall consist of members who shall be the members of the component county medical societies, and, who shall also be members in good standing of the American Medical Association, and who have been certified to the headquarters of this Society, and all of whose dues and assessments for the current year have been received by the secretary.

SEC. 2. Those members who have been elected to honorary membership by the various component county societies may be enrolled as honorary members of this Society upon approval of the Council. These honorary members shall enjoy all the rights of membership, and their dues to the State Society shall be remitted.

* COMMENT: In October 1964, the House of Delegates directed that action interpretive of the Constitution and Bylaws be indicated by annotation to the appropriate provision. This has been done beginning with 1964. This printing shows amendments through May 1966.

ARTICLE V

HOUSE OF DELEGATES

The House of Delegates shall be the legislative body of the Society, and shall consist (1) of delegates elected by the component county medical societies, and one delegate representing each Section of the Society organized under the Bylaws and (2) the officers of the Society enumerated in Section 1 of Article IX of this Constitution, and past presidents of the Society shall be ex officio members, but without the right to vote.

ARTICLE VI

COUNCIL

The Council shall be the Board of Trustees of this Society. The Council shall have full authority and power of the House of Delegates, between annual sessions, unless the House of Delegates shall be called into session as provided in the Constitution and Bylaws. It shall consist of the councilors and the immediate past president. The president-elect, the secretary, and the treasurer shall be ex officio members of the Council, but without the right to vote, and the president and speaker of the House of Delegates shall be ex officio members with such right to vote. A majority of its voting members shall constitute a quorum.

COMMENT: The above paragraph was amended in May 1963 to add the president and speaker of the House as voting members. In October 1964, the House approved a report to the effect that the Council has the authority to enforce the Constitution and Bylaws but not to change them. The action included an interpretation that the Council has the authority to determine its own committee structure and management policies. In the same year, the House recommended that the Council annually review services of Society consultants with consideration of such matters as utilization, efficiency and costs, with councilors reporting to the membership.

ARTICLE VII

SECTIONS AND DISTRICT SOCIETIES

The House of Delegates may provide for a division of the scientific work of the Society into appropriate sections, and for the organization of such councilor district societies as will promote the best interests of the profession, such societies to be composed exclusively of members of component county societies.

ARTICLE VIII

SESSIONS AND MEETINGS

SECTION 1. The Society shall hold an annual session during which there shall be at least two general meetings, open to all registered members, delegates and guests.

SEC. 2. The place for holding each annual session shall be fixed by the House of Delegates, or, by failure to act, such authority is delegated to the Council. The time for holding each annual session shall be approved by the Council.

SEC. 3. Special sessions of the House of Delegates shall be called by the Speaker on written request of twenty delegates representing 10% or more of the component county medical societies, or on request of a majority of the Council. When a special session is thus called, the Speaker shall set time and place. The Secretary shall mail a notice to the last known address of each member of the House of Delegates at least twenty days before the special session is to be held. The notice shall specify the time and place of the meeting and the purpose for which the session is called, and the session shall consider no business except that for which it is called.

COMMENT: Section 3 was amended in May, 1965.

ARTICLE IX

OFFICERS

SECTION 1. The officers of this Society shall be a president, a president-elect, a secretary, a treasurer, councilors from thirteen districts, and a speaker and vice speaker of the House of Delegates.

Each councilor shall be nominated only by the elected delegates of the county medical society or societies in the district for which he is nominated.

No person shall hold more than one of such offices concurrently.

COMMENT: Section 1, above, was amended in May 1963 by adding the last paragraph.

SEC. 2. The officers, except the councilors and the speaker of the House of Delegates, shall be elected annually. The term of the speaker shall be for two years. The terms of the councilors shall be for three years. No individual shall be permitted to serve more than three successive three-year terms as councilor wherever possible, and no more than a total of six terms of service as councilor shall be permitted. There shall be elected one councilor for each of the thirteen districts, except that in any councilor district embracing a membership of 250 or more, there shall be elected one additional councilor for each additional 250 members or major fraction thereof.

COMMENT: Section 2, above, was amended in May 1963 to make the speaker's term of office two years. The fourth sentence on number of councilor terms was added in May 1965.

As nearly as possible, one third of the members of the Council shall be elected each year. The secretary and the treasurer shall be elected by the Council. All these officers shall serve until their successors are elected and installed.

The president-elect shall automatically succeed the office of president at the conclusion of his one-year term of president-elect.

ARTICLE X

FUNDS AND EXPENSES

SECTION 1. Funds shall be raised by an equal per capita assessment on each component society. The amount of the assessment shall be fixed by the House of Delegates. Funds may also be raised by voluntary contributions, from the Society's publications and in any other manner approved by the House of Delegates. The treasurer and secretary shall submit an annual budget to the Council. All resolutions providing for appropriations shall be referred to the Council and all appropriations approved by the Council shall be included in the annual budget.

SEC. 2. The House of Delegates, by adoption of a bylaw, may provide for a special classification of members at per capita reduced dues where such classification may be applied generally throughout the state, and has no special application to individual members or to individual societies.

ARTICLE XI

REFERENDUM

At any general meeting of the Society it may, by a two-thirds vote, order a general referendum upon any question pending before the House of Delegates. The House of Delegates may, by a vote of its members, submit any question to the membership of the Society for its vote. A majority vote of all the members of the Society shall determine the question.

ARTICLE XII

SEAL

The Society shall have a common seal. The power to change or renew the seal shall rest with the House of Delegates.

ARTICLE XIII

AMENDMENTS

The House of Delegates may amend any article of this Constitution by a two-thirds vote of the members of the House present at any annual session, provided that such amendment shall have been presented in open meeting at the previous annual session, and that it shall have been published twice during the year in the bulletin or Journal of this Society, or sent officially to each component society at least two months before the meeting at which final action is to be taken.

BYLAWS

CHAPTER I

MEMBERSHIP

SECTION 1. The name of a physician on the official roster of this Society, after it has been properly reported by the secretary of his county society shall be *prima facie* evidence of membership and of his right to register at the annual session.

SEC. 2. No person who is under sentence of suspension or expulsion from any component society of this Society, or whose name has been dropped from its roll of members, shall be entitled to any of the rights or benefits of this Society.

SEC. 3. Each member in attendance at the annual session shall register, when his right to membership has been verified by reference to the records of this Society. No member shall take part in any of the proceedings of the annual session until he has complied with the provisions of this section of the Bylaws.

CHAPTER II

GENERAL MEETINGS

SECTION 1. The general meetings shall be open to all registered members and guests. At such time as may have been arranged, shall be delivered the annual addresses of the president and of the president-elect.

SEC. 2. The Council shall establish rules relating to requiring written papers of speakers. All papers read before this Society shall be its property. Each paper, when it has been read, shall be deposited with the secretary. Authors of papers read before

this Society shall not cause them to be published elsewhere until after they have been published in its Journal or returned by the Editorial Board. Authors who fail to observe this section shall be ineligible to appear on programs of the State Society for a period of five years.

CHAPTER III

HOUSE OF DELEGATES

SECTION 1. The House of Delegates shall meet annually at the time and place of the annual session.

COMMENT: In May 1964 this section was amended to call for an interim session, but in May 1966 this provision was repealed effective January 1, 1967.

SEC. 2. Each component county society shall be entitled to send each year one delegate or one corresponding alternate to the House of Delegates for each forty full-paid members or major fraction thereof in this Society provided, however, that each county society shall be entitled to at least one delegate or one corresponding alternate.

COMMENT: Number used as basis for determining representation changed from fifty to forty in May 1966.

The term "full-paid members," as used in this section, includes regular members of the Society, life members, affiliate members, associate members, educational members, and members whose dues are waived or remitted by official action of the Society. Special service members, resident members, partial-pay members, and members who are delinquent in dues payments shall not be included in the term "full-paid members."

For purposes of this section, the number of fully paid members as of the close of the calendar year preceding the first session of the House of Delegates at the annual meeting shall determine the number of delegates to which a county medical society may be entitled.

The secretary of each county society shall send a list of such delegates and alternates to the secretary of this Society* by the end of each calendar year preceding the year in which such delegates are elected to serve. Representation in the House of Delegates shall be contingent on compliance with the foregoing provisions.

SEC. 3. One-fourth of the members of the House of Delegates registered, representing one-fourth of the county medical societies in the state, shall constitute a quorum of the House of Delegates. All meetings of the House of Delegates shall be open to members of the Society.

SEC. 4. From among members of the House of Delegates, the speaker of the House of Delegates, for the purpose of expediting proceedings, shall appoint Reference Committees to which reports and resolutions shall be referred as follows:

a. On Credentials.

b. On Resolutions.

c. On Reports of Officers.

d. On Reports of Standing Committees.

He shall also appoint such other committees as may be considered by him to be necessary.

SEC. 5. The House of Delegates shall elect delegates to the House of Delegates of the American Medical Association in accordance with the Constitution and Bylaws of that body.

SEC. 6. The House of Delegates shall divide the state into councilor districts, specifying what counties each district shall include, and, when the best interest of the Society and the profession will be promoted thereby, organize in each a district medical society, of which all members of the component county societies shall be members.

COMMENT: In October 1964, the House of Delegates authorized a special committee of ten members, one from each congressional district, to study redistricting.

SEC. 7. The House of Delegates shall have authority to appoint committees for special purposes from among members of the Society who are not members of the House of Delegates. Such committees shall report to the House of Delegates, and may be present and participate in the debate on their reports.

SEC. 8. It shall approve all memorials and resolutions issued in the name of the Society before they shall become effective.

SEC. 9. Unanimous consent of the House of Delegates shall be required for the introduction of any new resolution or business not filed in proper form with the secretary's office of the Society thirty days before the first session of the House of Delegates. This section shall not apply to new business or resolutions presented by the Council, the constitutional officers, committees of the Society or of the House of Delegates, or officers of the House of Delegates.

CHAPTER IV

ELECTION OF OFFICERS

SECTION 1. The House of Delegates at its first meeting at the annual session shall elect a Committee on Nominations consisting of one delegate from each councilor district. The Committee on Nominations shall report the result of its deliberations to the House of Delegates in the form of a ticket containing the names of one or more members for each of the offices to be filled at that annual session. No two candidates for president-elect shall be from the same district. Each candidate for councilor must be a resident of the district for which he is nominated. Nominations for councilor shall be made from the floor and not from the Committee on Nominations.

SEC. 2. The report of the nominating committee and the election of officers shall be the first order of business of the House of Delegates at the third meeting of the House.

SEC. 3. All elections of officers, where more than one nomination is received, shall be by ballot and a majority of the votes cast shall be necessary to elect except for delegates and alternates to the American Medical Association. In case no nominee receives a majority of the votes on the first ballot, the nominee receiving the lowest number of votes shall be dropped and a new ballot taken. This procedure shall be continued until one of the nominees receives a majority of all the votes cast, when he shall be declared elected. In case no delegates or alternates for the American Medical Association receive on the first ballot a majority of the vote, the nominees shall be declared elected in the order of the highest number of votes received. until the allotted number shall have been chosen. In case of a tie vote for delegate or alternate, the tie shall be determined by lot.

SEC. 4. Nothing in this chapter shall be construed to prevent additional nominations being

* Chapter XI, Section 8 was revised in 1958 to require reporting of delegates by the end of the calendar year. This section editorially revised to conform with 1958 amendment.

made from the floor by members of the House of Delegates.

SEC. 5. No person known to have solicited votes for or sought any office within the gift of this Society shall be eligible for any office for two years.

CHAPTER V

DUTIES OF OFFICERS

SECTION 1. The president shall preside at all meetings of the Society; he shall appoint a Committee on Arrangements for the annual session and all committees not otherwise provided for; he shall deliver an annual address at such time as may be arranged, and shall perform such other duties as custom and parliamentary usage may require. He shall be the real head of the profession of the state during his term of office, and, as far as practicable, shall visit, by appointment, the various sections of the state and assist the councilors in building up the county societies, and in making their work more practical and useful.

SEC. 2. The president-elect shall act for the president in his absence or disability. If the office of president should become vacant the president-elect shall succeed to the presidency. In case of vacancy in the office of both president and president-elect the Council shall appoint one of its members as acting president until the next meeting of the House of Delegates.

SEC. 3. The treasurer shall give bond in such amount as the Council may provide. He shall demand and receive all funds due the Society, together with bequests and donations. He shall pay money out of the treasury only on a written order of the secretary; he shall subject his accounts to such examination as the House of Delegates may order, and he shall annually render an account of his doings and of the state of the funds in his hands.

SEC. 4. The secretary shall attend the general meetings of the Society and the meetings of the House of Delegates, and shall keep minutes of their respective proceedings. He shall be secretary of the Council. He shall be custodian of all record books and papers belonging to the Society, except such as properly belong to the treasurer, and shall keep account of and promptly turn over to the treasurer all funds of the Society which come into his hands. He shall provide for the registration of the members and delegates at the annual session. He shall, with the cooperation of the secretaries of the component societies, keep a card index register of all the legal practitioners of the state by counties, noting on each his status in relation to his county society, and shall transmit a copy of this list to the American Medical Association, transmitting to its secretary each month a report containing the names of new members and the names of those dropped from the membership roster during the preceding month. He shall conduct the official correspondence, notifying members of meetings, officers of their election and committees of their appointment and duties. He shall employ such assistants as may be ordered by the Council and shall make an annual report to the House of Delegates. He shall supply all component societies with the necessary blanks for making their annual reports, and shall collect from them the regular per capita assessments and turn the same over to the treasurer. The amount of his salary shall be fiixed by the Council.

The secretary shall maintain certified copies of each component county society's constitution and bylaws, together with any amendments to the same.

COMMENT: In October 1964, the House of Delegates affirmed the secretary as the chief executive officer charged with the execution of policy without assuming policy-making powers. He shall assist the officers in making decisions and taking actions, and share his convictions and argue their merits as requested. See October 1964 transactions of the House, Report of Reference Committee on Resolutions and Amendments to the Constitution and Bylaws (December 1964 issue of WISCONSIN MEDICAL JOURNAL).

SEC. 5. The speaker shall preside at the meetings of the House of Delegates and shall perform such duties as custom and parliamentary usage require.

SEC. 6. The vice-speaker shall officiate for the speaker in the latter's absence or at his request. In case of death, resignation, or removal of the speaker, the vice-speaker shall officiate during the unexpired term.

SEC. 7. The Council, as the executive body of the House, may devise an oath of office and have it administered through its Chairman to each constitutional officer and to each Councilor at an appropriate time and with an appropriate ceremony, upon their assuming office, such oath to state that each such officer and Councilor shall abide by and conduct his office in all respects in conformity with the Constitution and Bylaws of the Society and the decisions of its House and Council.

CHAPTER VI

COUNCIL

SECTION 1. The Council shall meet during the annual session, and at such other times as necessity *may* require, subject to the call of the chairman or on petition of three councilors. It shall hold an annual meeting, for purposes of organization and other business. Its chairman shall make an annual report to the House of Delegates.

COMMENT: Section 1, above, was amended in May 1964 to permit the Council to determine time of its meeting during the Annual Meeting. In October 1964, the House affirmed that the annual report of the chairman "shall include all major actions and policy decisions" with the report to be approved by the House. It authorized also that resolutions explanatory or interpretive of the Constitution and Bylaws be incorporated by way of annotation to them.

SEC. 2. Each councilor shall be organizer, peacemaker and censor for his district. He shall visit each county in his district at least once a year for the purpose of organizing component societies where none exist, for inquiring into the condition of the profession, and to keep in touch with the activities of and to aid in the betterment of the component societies of his district. Each councilor shall arrange for an annual conference with the societies within his councilor district, either through individual meetings or district meetings, at which time information shall be brought concerning activities of the State Medical Society and component societies within the district. He shall make an annual report of his work, and of the condition of the profession of each county in his district at the annual session of the Council. The necessary traveling expenses incurred by each councilor in the line of duties herein imposed may be allowed on a proper itemized statement, but this shall not be construed to include his expense in attending the annual session of the Society.

SEC. 3. The Council shall be the executive body of the House of Delegates and between sessions

shall exercise the power conferred on the House of Delegates by the Constitution and Bylaws.

The Council shall be the Board of Censors of the Society. It shall consider all questions involving the rights and standing of members, whether in relation to other members, to the component societies, or to this Society. All questions of an ethical nature brought before the House of Delegates or the general meeting shall be referred to the Council without discussion. It shall hear and decide all questions of discipline affecting the conduct of members or component societies, on which an appeal is taken. Its decision in all cases, including questions regarding membership in this Society, shall be final.

SEC. 4. Charters shall be issued to county societies only on approval of the Council, and shall be signed by the president and secretary of this Society. Upon the recommendation of the Council, the House of Delegates may revoke the charter of any component society whose actions are in conflict with the letter or spirit of this Constitution and Bylaws.

SEC. 5. In sparsely settled sections the Council shall have authority to organize the physicians of two or more counties into societies, to be suitably designed so as to distinguish them from district societies, and these societies, when organized and chartered, shall be entitled to all rights and privileges provided for component societies until such counties shall be organized separately.

SEC. 6. The Council shall provide for and superintend the issuance of all publications of the Society including proceedings, transactions and memoirs, and shall have authority to appoint an editor of the Journal and such assistants as it deems necessary. It shall prescribe the methods of accounting and through a committee shall audit all accounts of this Society, and with the treasurer, supervise the investment of funds. The Council shall adopt an annual budget providing for the necessary expenses of the Society, which shall be prepared and presented for its consideration by the treasurer and secretary at the first meeting of the Council each year. Its chairman shall submit an annual report to the House of Delegates, which shall specify the character and cost of the publications of the Society, the amount and character of all of its property, and shall provide full information concerning the management of all affairs of the Society which the Council is charged to administer. The Council may elect a vice chairman and create such further offices or combine or abolish them as it sees fit in the management of its affairs and in the discharge of its responsibilities.

SEC. 7. The Council may, by appointment, fill any vacancy in office not otherwise provided for which may occur during the interval between annual meetings of the House of Delegates; the appointee shall serve until his successor has been elected and has qualified.

When a councilor district initially qualifies for an additional councilor, such position shall be considered new and not a vacancy to which the Council is authorized to make an interim appointment. Such new position shall be filled by election at the next meeting of the House of Delegates in the manner provided by Article IX of the Constitution, and the initial term shall be so established as to maintain the election of substantially one-third of the councilors each year, as provided in Section 2 of said Article IX.

SEC. 8. The Council may elect as secretary one who need not be a physician nor a member of the Society.

SEC. 9. The salaries of all employees of the Society shall be fixed by the Council.

SEC. 10. The Council shall provide such headquarters for the Society as may be required to conduct its business properly.

CHAPTER VII

COMMITTEES

SECTION 1. The standing committees of this Society shall be as follows:

- A Commission on Scientific Medicine
- A Commission on Public Relations and Communications
- A Commission on Public Policy.
- A Committee on Grievances.
- A Commission on Hospital Relations and Medical Education.
- A Committee Advisory to the Woman's Auxiliary.
- A Committee on Cancer.

Unless otherwise expressly provided in these Bylaws, each of these committees or commissions shall consist of five members, each of whom shall serve for a term of five years, and no person shall serve on any one of the above committees or commissions more than three consecutive terms; nor shall any member serve concurrently on more than one such committee or commission. One member of each of these committees or commissions shall be appointed annually by the incoming president, by and with the consent of the House of Delegates, provided that where the House creates a new standing committee or commission the original appointments shall be for terms of one, two, three, four and five years, and thereafter for terms of five years each.

The chairman of each of the standing committees, or a member of the committee delegated by the chairman, shall make himself available to the appropriate reference committee of the House of Delegates for the purpose of amplifying or explaining the annual report of the standing committee of which he is a member.

SEC. 2. The Commission on Scientific Medicine shall consist of ten *appointed* members and the deans of the two medical schools in Wisconsin and the medical editor of the WISCONSIN MEDICAL JOURNAL. Each appointed member shall serve for a period of five years. The Commission on Scientific Medicine shall study the character and scope of the scientific proceedings of the Society and shall prepare the scientific program for the annual meeting. It shall likewise study the field of postgraduate education, making available, so far as lies within its power, program material for such postgraduate education both through programs of component societies and in such other ways as it may find feasible. It shall also be in charge of the scientific affairs of the Journal. Important questions of editorial policy shall be submitted to the Council of the Society and an annual report shall be made to the House of Delegates.

COMMENT: Section 2, above, was amended in May 1964 by Resolution No. 30, which increased the number of appointed members from five to ten, and clarified the Commission's responsibility in that it shall be in charge of *scientific* affairs of the Journal.

SEC. 3. The Commission on Public Relations and Communications shall consist of nine members appointed by the President of the Society. Appointments shall be so made that the terms of one-third of the members expire each year. The Commission on Public Relations and Communications shall study,

make recommendations, and implement approved activities to improve the distribution of medical service to the public. It shall also be responsible for all matters relating to industrial, rural health and safety. The Commission shall direct the public information and health education programs of the Society and shall assist the component societies in the conduct of similar programs. It shall also conduct an internal professional relations program to encourage active participation of all members in the affairs of the Society.

SEC. 4. The Commission on Public Policy shall consist of seven representatives from the membership at large, a representative from each Scientific Section created under Chapter XIII, Section 1, the president, president-elect, and the secretary. Representatives from the Scientific Sections shall be appointed by the president of the State Medical Society from a panel of three nominees submitted by each section, or in event of the failure of any section to submit nominees, the president may appoint a member from that specialty group. As nearly as possible the terms of one-third of the members representing the Scientific Sections shall expire each year, with each member being appointed for a term of three years, except that initial appointments shall be for one, two, and three year terms. Representatives from the membership at large shall be appointed pursuant to Section 1 of this Chapter. The Commission may elect its own executive committee of five members.

The Commission shall present to those public officers charged with the duty of enacting or enforcing measures in the interest of public health, all available information that may in any way assist such officers honorably to discharge their responsibilities.

COMMENT: The Commission on Public Policy was completely reconstituted by the House of Delegates in May 1964, by Resolution No. 29.

SEC. 5. The Committee on Grievances shall investigate all reported claims against members for compensation for injuries said to have resulted from malpractice. It shall determine as nearly as may be practicable the circumstances leading up to the making of the claim itself and the grounds on which the claim is based. The committee shall recommend to the Society from time to time such measures as it deems practicable for the limitation or removal of the causes of such claims. It may, at the request of any member against whom a claim has been made, place at his disposal such evidence as becomes available to the committee. If the committee believes a claim unjust, it shall, at the request of the member against whom the claim has been made, cooperate, so far as it can lawfully do so, with him and his counsel in defense against it. If the committee believes that the claim that it has investigated is a just claim, the committee may, at the request of the member against whom the claim was made, cooperate with him and his counsel, so far as it lawfully can do so, in effecting an equitable settlement. The committee shall submit a report of its proceedings at each annual meeting of the Society, covering the preceding year, in which report shall be included all recommendations made by the committee during the year looking toward the removal of the causes of claims based on alleged malpractice. The committee shall possess similar responsibilities where request is made to investigate complaints bearing upon a member's alleged violation of any provision of the Medical Practice Act.

The committee shall consist of nine members and the terms of one-third of its members shall expire each year, with each number appointed for a term of three years.

SEC. 6. The Commission on Hospital Relations and Medical Education shall consist of nine members, to be appointed by the President, with confirmation by the House of Delegates. As nearly as possible the terms of one-third of the members shall expire each year, with each member being appointed for a term of three years, except that initial appointments shall be for one, two, and three-year terms.

Its duties shall include the subjects of medical education, the interrelationships of the medical profession to hospital institutions, and all matters pertaining to the general subject of hospitals and the ability of the medical profession to provide quality medical care through their facilities.

The Commission shall be responsible to the Council in the interim between sessions of the House of Delegates, and the Council may assign one or more of its members to serve as liaison between the Council and the Commission.

COMMENT: In October 1964, the House of Delegates concurred in recommendation that this Commission retain jurisdiction of both hospital relations and medical education.

SEC. 7. The Committee Advisory to the Woman's Auxiliary shall consist of the chairman of the Council, the immediate past president, the president, the president-elect, and the secretary. Its principal duties shall be to advise state officers of the Auxiliary, particularly in the field of approval of new projects.

SEC. 8. The Committee on Cancer shall consist of a member appointed from each of the councilor districts of the State Society, and its principal duties shall be advisory to the Society and cooperating agencies as to those means best designed to aid in the prevention and alleviation of cancer. As nearly as possible, the terms of one-third of the members of the committee shall expire each year, with each committee member being appointed for a term of three years.

SEC. 9. The WISCONSIN MEDICAL JOURNAL shall be the official Journal of the Society.

CHAPTER VIII

DUES AND ASSESSMENTS

SECTION 1. The annual dues and assessments shall be determined by the House of Delegates, and shall be levied per capita on the members of the Society. They shall be payable on or before January 1 of the year for which they are levied. The secretary of each component society shall cause to be collected and shall forward to the offices of the Society the dues and assessments for its members, together with such data as shall be required for a record of its officers and membership. Any member whose name has not been reported for enrollment and whose dues for the current year have not been remitted to the secretary of this Society on or before March 31 shall stand suspended until his name is properly reported and his dues for the current year properly remitted.

An active member in good standing in his county society who has for thirty-five continuous years been a member of this State Society shall receive a special certificate and plaque indicating the completion of such period of membership.

SEC. 2. *Life Membership.* An active member who shall have been a member of his county and state medical societies in Wisconsin continuously for fifty

consecutive years shall be offered the status of a life member, and if he accepts shall enjoy full membership privileges, but shall be exempt from the payment of dues or assessments. He shall receive a certificate of life membership.

SEC. 3. *Affiliate Membership.* An active member in good standing in his county society may, upon the recommendation of the secretary and president of the county medical society and with approval of the State Medical Society, be granted affiliate membership with full voting and other privileges. Such membership shall be on an annual basis only, and shall be granted where such member suffers a physical or other disability preventing the practice of medicine with resulting serious financial reverses that would make payment of dues a matter of personal hardship.

SEC. 4. *Associate Membership.* A member in good standing in his county society, who has retired completely from the practice of medicine, may apply for associate membership. With approval of his county society and of the Council, such membership shall be granted on payment of $10 annual dues.

SEC. 5. *Educational Memberships.* Physicians engaged solely in educational and research activities, and no part of whose income is derived from the private practice of medicine, shall be eligible to full membership in this Society, with all the privileges and responsibilities of membership, upon the payment of annual dues equal to approximately 75 per cent of that annually determined for full dues-paying members. Such members shall be issued a certificate denoting such special membership, and the content shall be approved by the Council. Application for such membership shall be endorsed by the chief of service or other physician in supervision.

SEC. 6. *Scientific Fellows.* The Council may confer upon any person engaged in teaching one or more of the basic sciences at an accredited college or university, and not holding the degree of Doctor of Medicine, the status of Scientific Fellow. Scientific Fellows shall pay no dues or assessments, shall receive the Wisconsin Medical Journal, and shall be eligible to attend scientific sessions of the Society.

By proper provision of Constitution and Bylaws, either or both as may be necessary, a county society may create a similar classification.

COMMENT: Section 6, above, was created by the Council as Resolution No. 27 and adopted by the House of Delegates in May 1964.

SEC. 7. The record of payment of dues and assessments on file in the offices of the Society shall be final as to the fact of payment by a member and as to his right to participate in the business and proceedings of the Society and of the House of Delegates.

SEC. 8. Any county society which fails to make the reports required, at least thirty days before the annual session of the State Society, shall be held suspended, and none of its members or delegates shall be permitted to participate in any of the proceedings of the Society or of the House of Delegates.

CHAPTER IX

The ethical principles governing the members of the American Medical Association shall govern members of this Society. No member shall profess adherence or give support to any exclusive dogma, sect or school.

CHAPTER X

The deliberations of this Society, except as may be provided otherwise in the Constitution and Bylaws, shall be conducted in accordance with parliamentary usage as defined in Roberts' Rules of Order.

CHAPTER XI

SECTION 1. All county societies now in affiliation with the State Society or those that may hereafter be organized in this state, which have adopted principles of organization not in conflict with this Constitution and Bylaws shall, upon application to the Council, receive charters from this Society, provided that their constitutions and bylaws shall have been submitted to the Council and received its approval. Where a county medical society has lost or misplaced its constitution and bylaws, the model constitution and bylaws for county medical societies, as last approved by the Council, shall be deemed to apply.

COMMENT: Section 1, above, was amended in May 1964 by Resolution No. 28, by adding the last sentence.

SEC. 2. Only one component medical society shall be chartered in each county.

COMMENT: The House of Delegates in October 1964 recommended that county medical societies in their constitutions and bylaws limit successive terms of officers, increase size of boards of directors, and have wide representation on nominating committees.

SEC. 3. Each county society shall judge of the qualifications of its members, subject to review and final decision by the Council of the State Society. Every reputable and legally qualified physician who is a bona-fide resident of the same county shall be eligible to apply for membership so long as he does not practice nor profess to practice sectarian medicine, or engage in practice in a manner in conflict with the Principles of Ethics of the American Medical Association, or so conduct himself as to defeat the purposes for which the Society is organized and is operating. By proper provision of constitution and bylaws, either or both as may be necessary, the county society may require of an applicant for membership that he shall have resided within the jurisdiction of the society to which he is applying, for a period of one year as a condition precedent to election to membership; or the county society may provide that an applicant for membership first may be elected to membership for a term of only one year, with the provision that such membership shall then terminate, and the member resubmit to election, without limitation as to term, by vote of the Society.

A member of a component society whose license has been revoked, suspended, or voluntarily surrendered, shall be dropped from membership automatically as of the date of revocation, suspension, or voluntary surrender. The Council of the State Society shall have final authority to expel a member should a component county society fail to do so after being so requested by the Council.

A physician living near a county line may hold his membership in that county most convenient for him to attend, on permission of the component society in whose jurisdiction he resides.

A member who removes his principal practice from within the territorial limits of a component medical society in which he holds membership, to the territory of another component of the State Society, shall not be eligible to continue his membership in the first such society after the expiration of the calendar year in which such removal shall have occurred. Such member shall, however, be eligible to

apply for membership anew, or by transfer to the society in whose jurisdiction his principal practice shall have been removed.

By proper provision of Constitution and Bylaws, either or both as may be necessary, a county society may admit to membership those in training as hospital residents or as research fellows who are licensed to practice medicine and surgery in the state of Wisconsin, upon the payment of dues not to exceed $5 annually, of which at least $3 shall be remitted to the State Society, provided that any applicant so elected shall not be permitted such membership beyond a period of five years from the date of such election, and shall not be included as a "fully paid" member as that term is used in Section 2 of Chapter III.

SEC. 4. Any physician who may feel aggrieved by the action of the society of his county in suspending or expelling him shall have the right to appeal to the Council, whose decision shall be final. A county society shall at all times be permitted to appeal or refer questions involving membership to the Council of the State Society for final determination. The period of time within which appeal to the Council may be taken shall be limited to six months following the date of decision by the constituted authority of a component county medical society.

SEC. 5. In hearing appeals the Council may admit oral or written evidence as in its judgment will most fairly present the facts, but in the case of every appeal both as a board and as individuals, the councilors shall, preceding all such hearings, make efforts at conciliation and compromise.

SEC. 6. When a member in good standing in a component county society moves to another county in this state, he shall be given a written certificate of these facts by the secretary of his society, without cost, for transmission to the secretary of the society in the county to which he moves. Pending his acceptance or rejection by the society in the county to which he removes, such member shall be considered to be in good standing in the county society from which he was certified and in the State Society to the end of the period (respectively) for which his dues have been paid.

When a member in good standing in a component society removes his principal practice outside the borders of this State, he may continue his active membership in such component society and in the State Society by fulfilling all requirements of membership except residence pending his acceptance as a new or transfer member by the society of the area to which he has transferred his practice; provided, the period of such continuing memberships in this State shall cease upon his acceptance by a society in the new area of practice, and shall in no event continue beyond two full calendar years after that in which he transferred the location of his practice.

SEC. 7. Each county society shall have general direction of the affairs of the profession in the county, and its influence shall be constantly exerted for bettering the scientific, moral and material condition of every physician in the county. Systematic efforts shall be made by each member, and by the society as a whole, to increase the membership until it includes every eligible physician in the county.

SEC. 8. Each component county society shall elect one or more delegates, for a minimum term of two calendar years, and an equal number of individual alternates therefor to represent it in the House of Delegates of this Society, in accordance with Chapter III, Section 2, of these Bylaws. The term of office shall be pursuant to the constitution and bylaws of the county medical society but shall begin on January 1 of the year succeeding the election of such delegate. The secretary of each county society shall send a list of such delegates and alternates to the secretary of this Society by the end of each calendar year preceding the year in which such delegates are elected to serve. Representation in the House of Delegates shall be contingent on compliance with the foregoing provisions.

COMMENT: In Section 8, above, the two-year term was enacted by the House of Delegates in May 1964.

SEC 9. The secretary of each county society shall keep a roster of its members, and, if practicable, a list of nonaffiliated physicians, in which shall be shown the full name, address, college and date of graduation, date of license to practice in this State, and such other information as may be deemed necessary by Council. He shall send a copy of the program of each county meeting to his district councilor and to the secretary.

SEC. 10. Each county society shall appoint or elect one or more of its members as a member of an auxiliary Committee on Public Policy, and the county society secretary shall send his name and address at once to the secretary of this Society. The Committee on Public Policy of this Society shall formulate the duties of this auxiliary committee and supply each member with a copy. The auxiliary committeemen shall be accountable to their county societies and to the Council for prompt response to and continued cooperation with the Committee on Public Policy of this Society.

SEC. 11. This Society shall recognize as a special service member any physician who is in the armed forces of the United States, who has been licensed to practice medicine and surgery in Wisconsin, and who has not previously been a member of any county medical society. Such physician shall first have been accepted as a special service member by a component county society in accordance with the provisions of its constitution and bylaws, and the fact of such membership certified to this Society. Application for such special service membership shall not be dependent upon the place of previous residence or the place or period of previous practice, and such membership shall include all the rights and privileges of active membership excepting those of voting and holding office.

No dues shall be assessed against such member until the month following his discharge from the armed forces of the United States, at which time he shall pay prorated dues for the balance of the calendar year of his discharge from service. Special service membership shall lapse at the close of the calendar year of the discharge of each such member from service.

CHAPTER XII

SECTION ON MEDICAL HISTORY

Membership in this Section shall be composed of those interested in preserving medical history in Wisconsin. The Section shall have the power to elect its chairman and other officers, and the office of the secretary of the State Medical Society shall provide secretarial assistance to it.

Annual dues shall be fixed by the Section and shall not exceed $10 per year. The Section is empowered to accept contributions to its projects and may solicit funds in behalf of the Society. All funds of the Section shall be segregated, and expenditures from them shall be made under direction

and supervision of the Section, subject to approval of the Council.

Special membership certificates may be issued to those who become members of the Section, and displays may be developed by the Section for exhibit at the Society's Annual Meeting and elsewhere.

CHAPTER XIII

SCIENTIFIC SECTIONS

SECTION 1. The House of Delegates shall, if so recommended by the Council from time to time, establish such scientific sections within the Society as it may determine and shall have the power to combine, enlarge, or discontinue any or all of such sections so established.

SEC. 2. Such sections so established shall be based upon those divisions of medicine in which the various members possess a special interest, but qualifications for membership in any section may be prescribed by the members of such section, subject only to approval of the Council, except that scientific meetings of the section shall be open to all members in good standing of the State Medical Society.

SEC. 3. The officers of any such section shall be those prescribed by the members thereof. The terms of such officers shall be for the term of one year, but any officer may be reelected.

SEC. 4. The officers of any such section shall constitute the executive committee thereof, and a majority of the executive committee must vote with the majority of the members in order for any action of the section to be effective. The executive committee shall have the power to appoint such committees within a section as it deems necessary from time to time.

SEC. 5. No section shall have the power to bind the Society by any resolution or other action, or to publicize the same, unless the same shall first be approved by the House of Delegates, or by a majority of the members of the Council when the House of Delegates is not in session. No resolution adopted by any section shall be effective until likewise so approved.

SEC. 6. Each section so established shall have the privilege of electing a delegate and alternate to the House of Delegates.

CHAPTER XIV

SECTION 1. These Bylaws may be amended at any annual session by a majority vote of the delegates present at that session, if the proposed amendment has been properly submitted to the House of Delegates and has laid over for one day.

SEC. 2. Upon the adoption of this Constitution and these Bylaws, all previous Constitutions and Bylaws are thereby repealed.

SAVE YOUR "BLUE BOOK" ISSUE FOR FUTURE REFERENCE

This January "Blue Book" issue of the *Wisconsin Medical Journal* contains a variety of articles relating to medicolegal matters of direct concern to the physician in his relationship to governmental agencies. An annual presentation since 1924, the edition is unique among medical journals of the United States. Each one has been an outstanding legal service to members of the Society. A permanent file of these issues for future reference is recommended.

TAX DEDUCTIBILITY OF CERTAIN HEALTH AND ACCIDENT INSURANCE

Under recent Federal decisions *total premiums* paid for health and accident policies which provide indemnity for accidental loss of life, limb, sight or time, in addition to surgical-medical or hospital benefits, are deductible medical expenses for *federal* income tax purposes. Such ruling does not, of course, change the limitation permitting the deductibility only of the excess of medical expenses over 3% of adjusted gross income up to the applicable maximum.

Previously the most that could be deducted on a policy which combined surgical-medical and hospital benefits with time loss or similar coverage was that portion of the total premium which represented an allocation of the surgical-medical or hospital benefits. In the case of the Provident plan carried by members of the State Medical Society, this was $17.00, only a minor part of the total average premium paid by member physicians.

Under the recent decisions *total premiums* are deductible even though only *part* of each premium is attributable to surgical-medical or hospitalization benefits.

Because Wisconsin has recently adopted the medical deduction provisions of the Federal income tax laws, the same deductions will be allowed for 1966 Wisconsin income tax purposes.

PRINCIPLES OF MEDICAL ETHICS of the AMERICAN MEDICAL ASSOCIATION

PREAMBLE

These principles are intended to aid physicians individually and collectively in maintaining a high level of ethical conduct. They are not laws but standards by which a physician may determine the propriety of his conduct in his relationship with patients, with colleagues, with members of allied professions, and with the public.

Section 1.—The principal objective of the medical profession is to render service to humanity with full respect for the dignity of man. Physicians should merit the confidence of patients entrusted to their care, rendering to each a full measure of service and devotion.

Section 2.—Physicians should strive continually to improve medical knowledge and skill, and should make available to their patients and colleagues the benefits of their professional attainments.

Section 3.—A physician should practice a method of healing founded on a scientific basis; and he should not voluntarily associate professionally with anyone who violates this principle.

Section 4.—The medical profession should safeguard the public and itself against physicians deficient in moral character or professional competence. Physicians should observe all laws, uphold the dignity and honor of the profession and accept its self-imposed disciplines. They should expose, without hesitation, illegal or unethical conduct of fellow members of the profession.

Section 5.—A physician may choose whom he will serve. In an emergency, however, he should render service to the best of his ability. Having undertaken the care of a patient, he may not neglect him; and unless he has been discharged he may discontinue his services only after giving adequate notice. He should not solicit patients.

Section 6.—A physician should not dispose of his services under terms or conditions which tend to interfere with or impair the free and complete exercise of his medical judgment and skill or tend to cause a deterioration of the quality of medical care.

Section 7.—In the practice of medicine a physician should limit the source of his professional income to medical services actually rendered by him, or under his supervision to his patients. His fee should be commensurate with the services rendered and the patient's ability to pay. He should neither pay nor receive a commission for referral of patients. Drugs, remedies or appliances may be dispensed or supplied by the physician provided it is in the best interests of the patient.

Section 8.—A physician should seek consultation upon request; in doubtful or difficult cases; or whenever it appears that the quality of medical service may be enhanced thereby.

Section 9.—A physician may not reveal the confidences entrusted to him in the course of medical attendance, or the deficiencies he may observe in the character of patients, unless he is required to do so by law or unless it becomes necessary in order to protect the welfare of the individual or of the community.

Section 10.—The honored ideals of the medical profession imply that the responsibilities of the physician extend not only to the individual, but also to society where these responsibilities deserve his interest and participation in activities which have the purpose of improving both the health and the well-being of the individual and the community.

Adopted June 7, 1957

Operations of the State Medical Society of Wisconsin and its divisions and related organizations—Wisconsin Physicians Service; Medicare Part B (Title 18); Wisconsin Medical Assistance Program (Title 19); *Wisconsin Medical Journal;* Charitable, Educational and Scientific Foundation; Military Dependents' Medical Care Plan of the U. S. Government in Wisconsin; and SMS Realty Corporation—are carried on in four buildings: the "home" building, a service and storage building, an Annex building, all located in a complex on the shore of Lake Monona; and the Smithback building located a mile south on the Belt Line.

STATE MEDICAL SOCIETY OF WISCONSIN

330 EAST LAKESIDE STREET

MADISON, WISCONSIN

The "Home" of the State Medical Society on the south shore of Lake Monona houses the Wisconsin Medical Journal, the Society's Blue Shield plan, general administrative offices, dining room, meeting room, and Council room. Nearly 200 committee and other meetings are held here annually.

Services to Members

Health Educational Activities

Voluntary Health Agency Contacts

Student Loans

Grievance Services

Museum of Medical Progress and Stovall Hall of Health

Executive Office Services

The Wisconsin Medical Journal

Life Insurance

Disability Income Protection

WPS Protection

Open Panel Program under Workmen's Compensation

Postgraduate Education Programs

Physician Placement

Medicolegal Consultation

Public Relations

Legislative Representation

Governmental Agency Contacts

Medical Economic Advice

Members, State Medical Society of Wisconsin*

Adams:
Janssen, M. L.
Weihe, A. R.

Adell:
Bemis, I. M.

Algoma:
Hopkins, R. G.
March, J. F.
Papendick, D. E.
Stiehl, C. W.

Allenton:
Fisher, R. S.

Alma:
Bachhuber, M. O.

Amery:
Arneson, O. N.
Byrne, W. R.
Dasler, H. A.
Ford, K. K.
Marra, M. G.
Whitlark, F. L.

Antigo:
Beattie, B. W.
Blink, D. V.
Cromer, R. W.
Curran, W. P.
Fox, T. C.
Garbisch, F. H.
Garritty, J. E.
Lambert, J. W.
McKenna, J. E.
Moore, G. E.
Roth, E. J.

Appleton:
Anderson, J. G.
Bonner, J. N.
Bravick, D. D.
Brei, F. A.
Carlson, G. W.
Chandler, W. W.
Claypool, Blaine, Jr.
Cunningham, P. M.
Curry, J. C.
Dafoe, W. A.
Danford, H. G.
DeCock, R. D.
Dungar, C. F.
Engstrom, D. P.
Erchul, J. W.
Evangelista, T. L.
Fenlon, C. E.
French, G. A.
Gallaher, D. M., Jr.
Giffin, W. S.
Gmeiner, J. E.
Graves, M. D.
Green, C. J.
Gross, H. T.
Grubb, W. B., Jr.
Hale, William H.
Hamel, H. H.
Harris, J. S.
Hauch, F. M.
Haza, B. J.
Hodges, P. C., Jr.
Huberty, F. J.
Kagen, M. S.
Keane, K. M.
Kennedy, R. O.
Kitzerow, E. B.
Konz, S. A.
Laird, J. W.
Landis, R. V.
Loescher, T. M.
Luther, T. W.
McCanna, P. R.
Meighan, P. P.
Meyers, C. L.
Mielke, E. F.
Mielke, J. E.
Miller, E. J.
Mueller, G. F., Jr.
Neidhold, C. D.
Nichols, G. P.
O'Boyle, R. F.
Petersen, G. J.
Plouff, L. T.
Querol, J. T.
Raney, E. H.
Rankin, F. J.
Richards, W. R.
Russell, J. H.
Ryan, T. A.
Santos, G. P.
Savage, G. W.
Siegrist, K. J.
Simenson, R. S.
Slette, D. R.
Sullivan, J. F.
Taylor, A. C.
Veum, J. S.
Warren, J. L.
Weissler, J. B.
Williams, L. P.
Wright, Frank, Jr.
Young, J. J.
Zeiss, E. J.
Zeiss, J. C.

Arcadia:
Chisholm, T. P.
Zimmerman, Lois

Argyle:
Hunter, R. E.

Ashland:
Bargholtz, W. E.
Grand, C. A.
Grigsby, R. O.
Jauquet, J. M.
Koeller, A. A.
Kreher, J. E.
Larson, H. H.
Morrow, K. A.
Prentice, B. C.
Prentice, J. W.
Sandin, H. V.
Sneed, R. J.
Stanley, R. A.
Tucker, W. J.

Athens:
Regehr, E. H.

Augusta:
Moland, O. G.
Thieda, E. S.

Baldwin:
May, J. A.
Olson, C. A.
Sargeant, G. M.
Torkelson, L. B.

Balsam Lake:
Burdette, Stella I.

Bangor:
Ruppenthal, K. P.

Baraboo:
Edwards, A. C.
Hannan, K. D. L.
Hansel, R. G.
Holmen, G. J.
Huth, M. F.
Pearson, C. R.
Siebert, J. T.
Weston, E. L.

Barron:
MacMillan, D. G.
Strang, C. J.
Whaley, R. C.

Bayfield:
Moody, L. W.

Bear Creek:
Morneau, L. F.

Beaver Dam:
Bayley, H. G., Jr.
Bender, R. I.
Bergen, P. M.
Boock, R. F.
Cook, R. S.
Corso, Xavier
Damon, R. A.
Davis, T. C., Jr.
Drescher, G. G.
Erickson, N. W.
Funcke, Wm. E.
Glunz, P. R.
Klomberg, G. H.
Kores, A. B.
Link, D. L.
Qualls, C. L.
Richards, W. G.
Roberts, R. R.
Rowan, T.
Snook, W. H.
Szweda, J. A.
Taake, E. R.
Urbanek, R. E.
Vrabec, A. P.
Way, R. W.
Welsch, J. M.
Wohlwend, E. B.

Belgium:
Dorr, R. H.

Belleville:
Donlin, W. F.

Beloit:
Babb, J. L.
Baldwin, R. M.
Beltran, J. C.
Brillman, L. P.
Carney, C. M.
Carter, K. L.
Chancey, R. L.
Clark, D. M.
Fitzgerald, W. M.
Flarity, T. H.
Frank, Jordan
Freeman, W. S.
Glesne, O. G.
Greenfield, B. E.
Gunderson, R. H.
Johnson, F. K.
Jones, E. T.
Kasten, H. E.
Kishpaugh, H. W.
Kleppe, L. W.
Lakritz, L. W.
Lang, T. J.
Matthews, G. C.
Mauermann, W. J.
Pollard, W. H., Jr.
Pruett, W. A.
Qui, F. L.
Raube, H. A.
Sanderson, R. J.
Scholten, W. A., Jr.
Schwaegler, R. R.
Springberg, J. C.
Thayer, R. A.
Thomson, G. H.
Tuftee, A. O.
Twyman, A. H.
Wagelie, R. G.
Woodington, G. F.

Berlin:
Koch, H. C.
Koch, J. C
Osicka, S. R.
Schmidt, E. M.
Seward, L. J.
Sievers, D. J.

Big Bend:
Raschbacher, J. L.

Birnamwood:
Damp, O. E.

Black Creek:
Nepomuceno, R. A.

Black River Falls:
Daniells, A. S.
Holder, R. L.
Krohn, Eugene
Krohn, Robert
Noble, J. H.
Thurow, R. M.

Blair:
Schneider, O. M.

Bloomer:
Asplund, M. W.
Clauson, C. T.
Hudek, D. F.
Murphy, P. W.

Bloomington:
Edwards, P. K.

Bonduel:
Grover, W. W., Jr.
Stuff, Patricia J.

Boscobel:
Freymiller, E. F.
McNamee, J. R.
Mueller, C. E.
Randall, E. M.

Brandon:
Adams, H. G.

Brillion:
DeArteaga, Julio

Brodhead:
Hein, W. E.
Stuessy, M. W.

Brookfield:
Bemis, E. L.
Brown, D. H.
Deeds, E. C.
Green, R. E.
Jennison, M. R.
Jurisic, Anthony
Mann, D. H.
Meves, T. F.
Nemcek, A. A.
Owen, N. L.
Pavlic, R. S.
Roth, D. A.
Sewell, R. H.
Stoklos, Michael
Teresi, J. L.
Toepfer, R. A.
Viel, R. S.
Werts, K. G.
Wood, D. L.
Wright, I. V.

Brown Deer:
Kohne, B. D.
Macksood, J. M.

Brownsville:
Friedrich, L. E.
Ries, M. F.

Bruce:
Whalen, M. L.

Burlington:
Baker, D. J.
Erickson, L. W.
Gander, E. P.
Granzeau, H. W.
Krismer, G. J.
McNeel, Laird
Sroka, Wm. C.
Van Liere, J. D.
Wheaton, R. C.

Butler:
Schoeneman, R. H.

Butternut:
Boldt, R. E.

Cadott:
Bowe, C. T.
Haines, B. J.
Zenner, C. E.

Cambridge:
Amundson, K. K
Nemec, George, Jr.

Campbellsport:
Hoffmann, L. A.

* As of Dec. 31, 1966.

Casco:
Kerscher, E. J.

Cashton:
Mauel, N. M.

Cassville:
David, J. J.

Cedarburg:
Blanchard, P. B.
Huckaby, A. L.
Hurth, O. W.
Katz, H. J.
Kippenhan, J. E.
Misch, Allen

Cedar Grove:
Jensen, J. S.

Chetek:
Adams, R. W.
Bannister, F. M.
Clarke, G. S.

Chilton:
Humke, E. W.
Humke, K. R.
Knauf, J. W.
Pili, D. B., Jr.

Chippewa Falls:
Brown, F. J.
Dahl, D. A.
Hatleberg, C. B.
Hatleberg, E. A.
Henske, W. C.
Kemper, C. A.
Picotte, L. W.
Rahn, B. F.
Sazama, F. B.
Sazama, J. J.
Windeck, J. L.

Clear Lake:
Campbell, L. A., Jr.

Clinton:
Thomas, W. O.

Clintonville:
Arnold, W. G.
Auld, Irving
Bate, L. C.
Caskey, H. S.
Reichle, R. I.
Topp, C. A.

Cochrane:
Meili, E. A.

Colby:
Koch, James W.
Pfefferkorn, E. B.
Pfefferkorn, E. D.

Coleman:
Graner, L. H.

Colfax:
Earnhart, Harlan
Felland, O. M.

Colgate:
Domann, W. G.

Columbus:
Chell, C. F.
Poser, J. F.
Poser, R. F.
Shearer, C. E.

Conover:
Halloin, J. E.

Cornell:
Hendrickson, R. L.

Cottage Grove:
Vogt, G. H.

Crandon:
Moffet, D. V.
Rathert, Burton S.

Crivitz:
Settlage, H. A.

Cross Plains:
Lappley, W. F.

Cuba City:
King, C. S.
Stone, M. M.
Taylor, H. W., Jr.

Cudahy:
Abrams, J. E.
Chelius, C. J.
Cornell, J. W.
Fine, J. M.
Fons, J. W., Jr.
Frederick, J. J.
Harned, R. K.
Homsey, J. J.
Kash, S. H.
Lando, D. H., Jr.
Landsberg, Manfred
Latorraca, Rocco
Marcich, Z. P.
Nuyda, D.
Oddis, N. A.
Potos, W. B.
Ruffio, R. A.
Tabet, R. C.
Vitulli, V. N.

Cumberland:
Anderson, R. M.
Jirsa, H. O.
Lund, R. E.

Darlington:
McGreane, N. A.
Olson, Lyle L.
Ruf, D. F.

Deerfield:
Ingwell, C. L.

De Forest:
Grinde, J. M.

Delafield:
Olsen, L. C. J.
Wade, Chester

Delavan:
Galgano, R. S.
Martin, J. E., Jr.
O'Keefe, F. L.
Roesler, M. J.
Smiley, G. A.
Werbel, H. J.
Woods, Wm. C.

Denmark:
Hering, G. V.
Michna, C. T.

De Pere:
Keiser, O. S.
Levitas, I. E.
Merline, G. B.
Waldkirch, B. P.
Waldkirch, R. M.

De Soto:
Bolstad, H. A.

Dodgeville:
Buckner, H. M.
Downs, D. R.
Hamilton, W. P.
Morton, H. H.
Rasmussen, N. G.

Dousman:
Pecarski, Miodrag

Durand:
Bryant, R. J.
Myers, M. E.
Springer, J. P.

Eagle River:
Colgan, J. J.
Jacobson, L. L.
Oldfield, R. A. A.

East Ellsworth:
Klaas, F. B.

East Troy:
Kohn, Louis

Eau Claire:
Aitken, H. M.
Anderson, F. G.
Angell, D. C.
Aronson, Willard
Bates, P. J.
Beckfield, W. J.
Beebe, G. W.
Bjurstrom, R. O.
Brousseau, E. R.
Brown, R. C.
Buckley, R. A.
Cameron, W. G.
Dibble, J. B.
Fink, R. J.
Finucane, P. J.
Frank, R. C.
Fuson, H. S.
Gericke, J. T., Jr.
German, K. L.
Giffen, G. G.
Gonlag, Harry
Graber, R. E.
Griffith, D. R.
Haag, A. F.
Henke, F. W.
Henke, S. L.
Hilker, A. W.
Hill, E. F.
Hoff, D. E.
Hudson, R. F.
Huston, H. C.
Ihle, C. M.
Kass, R. M.
Kelley, W. M.
Kennedy, R. L.
Kilkenny, T. E.
Kinsman, F. C.
Klein, A. J.
Larkin, W. B.
Lorenz, A. A.
Lotz, R. M.
Manz, W. R.
Martins, J. K.
Mautz, W. T.
McAfee, G. D.
Midelfart, Peter A. H.
Miller, D. F.
Miller, G. E.
Moberg, T. D.
Nester, H. D.
Nezworski, L. G.
Niver, E. O.
Ostenso, R. S.
Owen, G. E.
Paulson, W. O.
Raymond, L. A.
Richards, R. R.
Schulz, Emil
Sorensen, H. E.
Spelbring, P. G.
Sperry, V. A.
Stewart, K. E.
Strand, R. C.
Thimke, H. E.
Tobin, J. M.
Wahl, G. E.
Walter, K. E.
Walter, Wm.
Willison, D. M.
Wishart, J. H.
Ziegler, J. E. B.

Edgar:
Schulz, H. A.

Edgerton:
Boulet, W. J.
Burpee, G. F.
Cohen, D. A.
Falk, V. S., Jr.
Pavlik, K. K.
Shearer, T. M.
Sumner, W. C.

Elcho:
Dailey, D. W.

Elkhart Lake:
Heiden, H. H.
Martineau, J. E.

Elkhorn:
Bill, K. C.
Hatfield, M. E.
Helmbrecht, M. G.
Mol, H. R.
Rawlins, J. A.
Rogers, R. J.
Sablay, Nonito
Sorenson, E. D.

Ellsworth:
Jonas, E. R.

Elm Grove:
Barta, R. F.
Bauer, K. T.
Denio, M. J., Jr.
DiMiceli, Ettore, Jr.
Dudenhoefer, P. A.
Erwin, C. P.
Erwin, C. J. R.
Grade, J. O.
Hanauer, M. M.
Hanson, E. R.
Hepperla, R. L.
Klingbeil, R. E.
Mateicka, W. E.
Millington, P. E.
Myers, S. C.
O'Connor, T. M.
Redlin, R. R.
Settimi, A. L.
Shockley, B. F., Jr.
Van Gilder, J. H.
Wendt, W. P.
Wisniewski, J. H.
Zurheide, H. J.

Elmwood:
Springer, F. A.

Elroy:
Balder, R. B., Jr.

Ettrick:
Rogne, C. O.

Evansville:
Gray, R. J.
Gray, Roger S.
Sorkin, S. S.

Fall Creek:
Zboralske, F. F.

Fennimore:
Bailey, M. A.
Howell, E. C.
Shields, C. H., Jr.

Fond du Lac:
Becker, N. O.
Bissegger, Arnold
Borsack, K. K.
Carlovsky, R. E.
Cerny, F. J.
Charles, J. E.
Cullen, R. E.
Devine, J. C.
Flanagan, C. M.
Gardner, L. C.
Guth, H. K.
Hagel, Hans
Huebner, J. S.
Hutter, A. M.
Jones, L. E.
Keenan, L. J.
Kendell, W. G.
Klef, H. J.
Koll, J. H.
Lawrence, D. L.
Leonard, C. W.
Llewen, B. E.
Longstreth, C. R.
Mauthe, Howard
McCormick, D. W.
McCullough, James C.
McCullough, John C.
McLane, Hugh J.
Meisinger, G. F.
Myers, W. E.
Pallin, Josephine N.
Parrish, J. G., Jr.
Pawsat, E. H.
Peters, John
Peterson, C. R.
Rupple, J. H.
Schroeder, R. W.
Shahrokh, D. K.
Sharpe, H. R.
Sharpe, H. R., Jr.
Sisk, J. A.
Smith, D. A.
Smith, E. V., Jr.
Steube, R. W.

Swan, J. C.
Theis, E. H.
Theisen. S. A.
Thomas, H. R., Jr.
Treffert, D. A.
Twohig, D. J., Jr.
Vetter, E. W.
Vrtilek, M. R.
Waffle, R. L.
Waldschmidt, W. J.
Wier, J. S.
Wojta, W. C.
Yockey, J. C.

Forestville:
Hirschboeck, J. G.

Ft. Atkinson:
Aufderhaar, H. W.
Bates, D. E.
Beran, F. V.
Gueldner, L. H.
Handeyside, R. G.
Hanson, O. H.
Harris, J. J.
Hunsader, H. N.
Russell, J. C.
Sholtes, C. A.
Vognar, S. F.

Fox Point:
Peters, L. M.
Silberman, Jack
Thompson, L. H.

Franklin:
O'Leary, W. J., Jr.

Franksville:
Harris, W. C.

Frederic:
Andrews, W. C.
Fischer, W. A.
Moore, R. M.
Schwab, D. F.

Fremont:
Gloss, A. J.

Galesville:
Alvarez, R. L.
Moen, C. B.
Rohde, E. P.

Genoa City:
Dekker. Cornelis

Germantown:
Lastrilla, R. S.

Gillett:
Klutzow, F. W.

Glendale:
Brazy, R. R.
Truszkowski, A. J.

Glenwood City:
Limberg, A. W.
Limberg, P. W.

Grafton:
Fueredi, Adam
Pelant, K. F.
Seldl, J. A.

Grantsburg:
Hartzell, R. L.
Hartzler, P. L.

Green Bay:
Andrew, R. C.
Angus, D. C.
Austin, S. D.
Benkendorf, Charles
Beno, T. J.
Blackburn, M. D., Jr.
Boersma, J. J.
Bolles, C. S.
Bramschreiber, J. L.
Brault, R. G.
Brusky, A. H.
Brusky, E. S.
Caffrey, J. F.
Clark, E. V., Jr.
Cook, F. D.
Crawford, C. W.
Danaher, H. H.
Dega, F. J.
Denys, G. F.
Dettmann, J. E.
Dupont, A. J.
Edelblute, L. H.
Erickson, M. R.
Falk, M. J.
Forbes, K. A.
Ford, J. L.
Ford, W. W.
Freedman, A. L.
Gallagher, D. J.
Gehring, J. V.
Goelz, J. R.
Grace, J. B.
Green, J. R.
Griggs, S. L.
Groessl, P. J.
Gruesen, R. A.
Guthrie, J. M., Jr.
Hagerty, W. T.
Haines, A. W.
Hammes, D. A.
Hart, L. E.
Heitzman, H. H.
Hitch, O. M.
Hoegemeier, H. W.
Hoops, H. J., Jr.
Jensen, R. E.
Johnston, R. E.
Kaftan, G. R.
Kaufman, J. E.
Killeen, E. R.
Killins, J. A.
Killins, W. A.
Kuehl, F. O.
Kulkoski, Bernard
Kullerstrand, D. S.
Leicht, T. R.
Le Mieux, G. E.
LeTellier, M. S.
Lynn, T. E.
Mackey, J. P.
MacMullen, Wallace, II
Marnocha, J. R.
Martin, J. E.
McCarey, Arthur J.
McCormick, R. A.
McGuire, G. E.
McNeal, W. E.
Mickle, K. C.
Miller, L. C.
Milson, B. I.
Milson, Louis
Mokrohlsky, J. F.
Myers, R. L.
Nadeau, E. G.
Nadeau, E. G., Jr.
Nellen, J. W.
Neu, V. F.
Nicolaus, W. H.
Ottum, J. A.
Oudenhoven, R. C.
Philipp, L. D.
Rahr, H. C.
Randall, J. H.
Rian, Oliver
Robb, J. J.
Rose, R. J.
Rothe, C. A., Jr.
Sandmire, H. F.
Schlbly, W. J.
Schmidt, R. T.
Schumacher, J. P.
Sehring, F. G.
Shea, D. W.
Sherwood, D. L.
Shinners, G. M.
Sipes, D. R.
Slightam, P. E.
Smith, C. C.
Stauff, G. R.
Stiennon, O. A.
Stoehr, B. J.
Stoll, W. M.
Sullivan. Donel
Terner, E. A.
Theiler, G. J., Jr.
Thompson, L. L.
Troup, R. H.
Troup, R. L.
Troup, W. J.
Urban, Frank
Von Heimburg, Roger
Wallerius, J. F.
Wochos, R. G.
Wunsch, C. A.
Zucker, K. L.

Greendale:
Brown, R. J.
Kuglitsch, E. F.
Wengelewski, H. B.

Greenfield:
Bond, J. T.
Mohanty, R. K.
Weis, T. W.

Green Lake:
Leininger, A. T.

Greenwood:
Olson, W. A.

Gresham:
Litzen, F. L.

Hales Corners:
Altstadt, J. F.
Berg, J. F.
Bottum, M. W.
Clemence, J. A.
Czajka, J. J.
Damiano, N. F.
Everts, E. L.
Gillespie, C. J.
Grosshandler, S. L.
Jachowicz, R. B.
La Susa, T. J.
Pierce, D. F.
Sortor, R. F.
Wolf, R. C.

Hartford:
Algiers, J. L.
Arrambide, George
Hellmuth, G. A.
Hoffmann, J. G.
Hoffmann, W. C.
Kern, T. J.
Mally, M. J.
Monroe, M. E.
Nickels, R. J.
Quackenbush, E. C.
Quandt, V. V.

Hartland:
Chambers, R. K.
Ridley, J. F.
Samuelson, Clarence

Hawthorne:
Farias, O. A.

Hayward:
Baertsch, L. M.
Callaghan, D. H.
Sahs, M. H.
Stang, H. M.
Wyant, M. E.

Hazel Green:
Farbstein, M. E.
Klein, G. J.
Ware, R. J.

Hilbert:
Pinney, J. C.

Hillsboro:
Boston, T. E.
Sanford, L. L.

Hollandale:
Marshall, S. B.

Horicon:
Karsten, F. A.
Schulz, N. H.
Schutz, W. J.

Hortonville:
Bergwall, J. G.
Towne, W. H.

Hudson:
Anderson, M. G.
Bourget, G. E.
Cornwall, M. A.
Hopkins, G. J.
Timp, L. F.

Hurley:
Martinetti, D. J.

Hustisford:
Goetsch, O. F.

Independence:
Meyer, C. F.

Iola:
Hollero, N. J.

Jackson:
Albrecht, J. E.

Janesville:
Apfelbach, G. L.
Baker, C. S.
Baumgartner, M. M
Betlach, Dorothy W.
Betlach, Eugene H.
Chicks, C. O.
Clark, W. T.
Dodge, R. K.
Donkle, M. J.
Farnsworth, R. W.
Fitzgerald, G. P.
Frechette, F. M.
Freitag, S. A.
Gilbertsen, C. R.
Gredler, G. P.
Gutmann, G. E.
Hansen, T. R.
Hartlaub, E. S.
Holland, R. A.
Karzel, R. P.
Knepel, Donald
Koch, V. W.
Kronquist, G. E.
Lakritz, Amrum
Levin, Harland
Llewellyn, M. B.
McNichols, E. F.
McSweeny, A. J.
Nash, C. B.
Neeno, Katsumi
Nienhuis, H. D.
Nolta, R. T.
Nuzum, T. O.
O'Brien, J. N.
Odland, P. K.
Otterholt, E. R.
Overton, R. S.
Pember, J. F.
Pennepacker, J. S.
Peters, E. E.
Peterson, Geo. H.
Purdy, M. F.
Rau, Esther L.
Reinardy, A. L.
Reinardy, E. W.
Russo, F. R.
Sabado, E. F.
Sargeant, T. S.
Schroder, John R.
Schroeder, Jack D.
Sholl, P. R.
Smith, D. A.
Snodgrass, H. M.
Thomas, G. L.
Tordoff, J. J.
Tregoning, P. C.
Vogel, T. L.

Jefferson:
Busse, A. A.
Quandt, C. E.
Quandt, R. W.
Siedenburg, Richard

Johnson Creek:
Wendt, F. A.

Juneau:
Haessly, F. G.
Heath, H. J.

Kaukauna:
Bachhuber, A. E.
Bachhuber, A. M.
Behnke, G. A.
Boyd, G. L.
Cherkasky, Simon
Jeffrey, J. S.
Russo, J. G.
Skibba, J. P.
Wolfmeyer, W. W.

Kenosha:
Ambro, P. J.
Armstrong, G. F.
Ashley, R. W.

Balcjunas, Vitoldas
Bandelin, V. R.
Barnes, E. H., III
Bilak, R.
Bjork, H. A.
Bode, M. J.
Bonell, B. T.
Burhani, A. W.
Burnett, R. G.
Capelli, P. A.
Conzelman, D. R.
Creighton, L. H.
Creswell, C. M.
Cruz, M. R.
Davin, C. C.
Davis, D. W.
DeFazio, S. F.
Donnell, W. S.
Duncan, J. T., Jr.
Fai, L. L.
Ferwerda, J. R.
Garren, J. T.
Goldstein, D. N.
Graves, J. P.
Halfon, Nesim
Hauschild, W. A.
Heck, J. A.
Hill, B. Spalding
Holt, S. H.
Horsley, D. B.
Kent, L. T.
Kleinpell, W. C.
Lipman, W. H.
Lokvam, L. H.
Lutz, J. J.
Meeter, U. L.
Mercado, R. C.
Milliken, L. D., Jr.
Morrow, C. A.
Mudge, W. A., Jr.
Olsman, Louis
Pamukcu, F.
Pearson, J. B.
Pechous, C. E
Pechous, C. E., Jr.
Peterson, C. E.
Powell, R. A.
Rafferty, H. P.
Rattan, W. C.
Rauen, L. M.
Richards, J. N.
Ruehlman, D. D.
Ruffio, A. F.
Sattler, C. A.
Schlenker, L. T.
Schulte, G. C.
Schwartz, G. J.
Schwartz, H. L.
Siegel, Morris
Swift, W. J.
Turner, Lewis, III
Wadina, G. S.
Wagner, H. B.
Weber, G. R.
Welsch, R. G.
Whetstone, O. H.
Williams, F. C., Jr.
Wilson, R. E.
Wood, Fredrick, Jr.

Kewaskum:

Edwards, R. G.

Kewaunee:

Lanier, A. S.
Lanier, Patricia F
Nosemann, R. M.
Wits, E. W.

Kiel:

Nauth, D. F.
Schultz, W. F.
Theiler, A. C.
Twohig, G. J.

Kimberly:

Gage, Ralph S.
Knoedler, W. H.

King:

McGinnis, H. J.

Kohler:

Gascoigne, C. C.
Rowe, D. M.

La Crosse:

Aiken, R. E.
Alvarez, Ubaldo
Anderson, E. M.
Anderson, N. P.
Anderson, P. D.
Bach, A. C.
Brailey, A. G., Jr
Britt, A. G.
Buchman, D. M.
Carlsson, E. S.
Cejpek, K. O.
Cook, A. A.
Copps, S. C.
Corser, D. H.
Da Costa, W. C.
Dalton, R. M.
Dietz, P. C.
Durst, J. B.
Egan, G. J., Jr.
Ellenz, G. B.
Ernst, F. W.
Fisher, A. L.
Flynn, R. E.
Fox, J. C.
Gallagher, F. J.
Gallagher, W. B.
Getz, Kaare
Gilbert, R. L.
Goodnough, D. E.
Gorenstein, L. M.
Green, R. M.
Guernsey, Gretchen
Gundersen, A. E.
Gundersen, A. H.
Gundersen, A. L.
Gundersen, Cameron
Gundersen, G. A.
Gundersen, Gunnar
Gundersen, S. B., Jr.
Gundersen, T. E.
Haidinyak, A. L.
Hayden, J. W.
Helliesen, P. J.
Hickey, A. W.
Himmelsbach, W. A.
Hullck, P. V.
Jones, W. J.
Joseph, L. G.
Kalfayan, Bernard
Lefsrud, J. B.
Leiby, R. W., Jr.
MacEwen, A. R.
Mansheim, B. J.
McCann, John P.
McGarty, M. A.
McKee, D. C.
McMahon, R. E.
McNamara, T. B.
Meis, P. J.
Mildelfort, C. F.
Miner, E. B.
Morgan, W. A.
Murphy, G. B., Jr.
Murphy, J. T.
O'Meara, M. T.
Perry, E. L.
Phlilips, P. W.
Pribek, R. A.
Ramlow, R. W.
Rasmus, R. B.
Richter, J. R.
Satory, J. J.
Scheurich, Mary B.
Schmidt, C. F.
Schmidt, L. R.
Schneeberger, E. J.
Schuldes, R. E.
Sevenants, J. J.
Shealy, C. N.
Shields, J. C.
Simones, J. J.
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Skemp, C. A.
Skemp, F. C.
Skemp, G. E.
Skemp, J J.
Skemp, J. T.
Skemp, S. J.
Slungaard, Rolv
Thompkins, D. G.
Uhrich, G. I.
Van Susteren, J. A.
Watunya, M. J.
Weeth, J. B.
Whiteway, R E.
Wolf, F. H.

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Bennett, R. P.
Murphy, J. E.
Pagel, H. F.

La Farge:

Lee, Connie

Lake Geneva:

Beattie, J. W.
Bischof, H. F.
Hindall, B. C.
Hudson, E. D.
Jeffers, D. H., Jr.
Rauch, A. M.

Lake Mills:

Eck, G. E.
Effenhauser, Manfred
Liebenow, R. R.
Netzow, E. J.
Peterson, M. G.

Lancaster:

Bauman, K. L.
Becher, L. E.
Carey, H. W.
Hillery, G. C.
Houghton, E. M.

Land O' Lakes

Eickhoff, E. C.

Laona:

Castaldo, E. F.
Ovitz, E. G.

Lena:

Rose, J. F.

Little Chute:

Buchanan, K. E.
Van Lieshout, F. X.

Lodi:

Irwin, W. G.

Loyal:

Hable, A. P.

Luxemburg:

Majeski, H. E.

Madison:

Aageson, C. W.
Ainslie, R. B.
Albright, E. C.
Albright, J. G.
Allen, J. R.
Allin, R. N.
Anderson, A. D.
Anderson, Jeanne
Anderson, R. B.
Andrew, R. B.
Angevine, D. M.
Ansfield, F. J
Ansusinha, Tamnit
Ashman, H. C.
Backs, M. F.
Backwinkel, K. D.
Bamforth, Betty J.
Barbour, J. H.
Barreto, R. S. A.
Barta, R. A., Jr.
Bartlett, W. H.
Batson, J. F.
Bauman, B. J.
Baumblatt, M. J.
Beilman, R. L.
Belknap, E. L., Jr.
Benfield, J. R.
Benish, G A.
Bennett, Maxine
Berg, Mary C.
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Bernard, F. D.
Bernhardt, L. C.
Bessire, M. C.
Bjornson, Jon
Blancke, F. W.
Bloodworth, J. M. B., Jr.
Blum, F. G., Jr.
Bogle, W. C.
Bohlman, D. C.
Boldon, E. L., Jr.
Borenz, H. F.
Botham, R. J.
Brandabur, J. J.
Brandenburg, J. H.
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Briggs, R. C.
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Brittin, G. M.
Britton, D. M.
Brodhead, Wm. T.
Brown, J. G.
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Burg, R. M.
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Burke, Myra E.
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Byce, K. R.
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Calvert, Charlotte
Campbell, R. E.
Carter, H. M.
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Chase, S. L.
Cherry, J. D.
Chunn, A. G.
Clatanoff, D. V.
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Clinton, G. L.
Cohen, Marcus
Collins, R. F.
Connors, D. M.
Cookson, D. U.
Cooper, G. A.
Coryell, J. L.
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Crennell, E. H.
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Cunningham, M. A.
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Dally, A. D.
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Davis, F. A.
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Davis, M. D.
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Dimond, W. B.
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Doolittle, J. W.
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Epstein, Stephan
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Farrell, R. X.
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Fliegel, M. B.
Forster, F. M.
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Hill, N. A.
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Prouty, L. R.
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Schwindt, W. D.
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Shropshire, R. W.
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Smith, D. B.
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Straughn, R. A.
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Talbot, J. R.
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Tenney, Horace K., III
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Thung, N. S.
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Toussaint, J. B.
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Tybring, G. B
Uehling, D. T.
Urben, W. J.
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Van Gemert, J. G.
Vastola, A. P., Jr.
Vermund, Halvor
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Vogel, Heinz
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Walton, J. D.
Warrick, Louis F., Jr.
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Wasserburger, R. H.
Waters, D. D.
Waun, J. E.
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Weatherhogg, C. R.
Weinstein, A. B
Welke, E. G.
Westman, J. C.
Weston, C. B.
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Whitsitt, R. E.
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Williams, D. L.
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Winston, Margaret C.
Wirka, H. W.
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Wixson, R. C
Wolberg, W. H.
Wu, Nancy N.
Wylde, R. M
Wyner, S. F.
Yale, C. E.
Yeazel, R. V.
Ylitalo, W. H
Young, W. P.
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Manitowoc:

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Banker, R. J
Belson, H. J
Bonner, N. A.
Bush, R. D.
Davis, N. S., Jr.
Erdmann, N. C.
Gerndt, H. L., Jr.
Hammond, F. W
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Jacobi, M. A.
Karrmann, P. L., Jr.
Kobelt, C. C.
Kordecki, F. A.
Larsen, J. R.
Lynch, J. D.
MacLean, C. R.
Perry, T. K.
Pick, D. M.
Puestow, R. C.
Radl, C. J.
Randolph, R. C.
Randolph, W. C.
Rauch, W. A.
Rees, T. H.
Schaefer, H. E.
Scherping, W. H.
Schroeder, N. C.
Simon, G. M.
Smejkal, W. F.
Stannard, G. H., Jr.
Steckbauer, J. W.
Strong, R. G.
Teltgen, T. A.
Thorpe, R. F.
Wall, C. E.
Whereatt, R. R.
White, W. F.
Yost, R. G.

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Kampine, C. E.

Maribel:

May, J. H.

Marinette:

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DeWitt, R. S.
Koepp, C. E.
Moss, K. J.
Murray, R. C.
Pinegar, K. G.
Zeratsky, J. D.

Markesan:

Cupery, D. P.
Plueddeman, P. M.

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Schmidt, C. W.

Marshfield:

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Burns, J. L., Jr.
Custer, G. S., Jr.
Dasler, T. W.
Diaz-Esquivel, Jose
Doege, K. H.
Doege, P. F.
Dovenbarger, W. V.
Emanuel, D. A.
Fletcher, F. W.
Gandhi, Kishin
Geitz, Marten
Gouze, F. J.
Griese, G. G.
Heersma, J. R.
Heywood, R. M.
Heywood, W. H.
Hinke, D. H.
Kinkella, A. M.
Kruse, Francis, Jr.
Kunkel, J. A.
Lawton, B. R.
Lewis, R. F., Jr.
Lohrenz, F. N.
Macht, A. J.
Magnin, George E.
Manier, J. W.
Mason, R. W.
Moffat, N. A.
Mulvaney, J. J.
Nikolai, T. F.
Olsen, T. G.
Ottensmeyer, D. J.
Ousley, J. L.
Pederson, D. P.
Porter, G. E.
Potter, R. P
Ptacek, L. J.
Pyka, R. A.
Rice, T. J.
Richards, R. N.
River, G. L.
Rowe, R. J.
Rupel, J. W.
Salibi, B. S
Sautter, R. D.

Schloesser, L. L.
Schorr, W. F.
Silvis, S. E.
Suits, J. J.
Vedder, C. A.
Vedder, J. S.
Waters, H. S.
Williams, G. H.
Wink, R. H.

Mauston:

Griffin, V. M.
Hess, J. S., Jr.
Strong, Jack
Vedner, J. H.

Mayville:

Bachhuber, F. G.
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Parish, G. A.

Mazomanie:

Schultz, Isadore

McFarland:

Arnesen, R. B.

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Keuer, J. R.
Meyer, W. W.
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Nystrum, L. E.
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De Morest, H. F., Jr.
Gustafson, G. E., Jr.
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Jensen, F. G.
Jensen, R. A.
Larson, O. E.
Nebel, J. R.
Newby, K. G.
Pratt, G. N., Jr.
Schwei, G. P.
Wainscott, P. E.

Menomonee Falls:

Bibler, R. H.
Brennan, W. M.
De Guzman, E.
Dempsey, K. J.
Domann, W. A.
Dougherty, P. J.
Drayer, H. D.
Foley, J. J.
Hardman, D. R.
Harrington, K. J.
Heyrman, D. J.
Hofbauer, T. A.
Hoffman, J. R.
Klopf, H. M.
Riesch, J. D.
Schloemer, H. F.
Schmidt, R. D.
Wagner, G. R.

Menomonie:

Buckley, C. H.
Drescher, A. A.
James, J. R.
Lee, S. R.
Lumsden, William
McMahon, A. E.
Melms, F. A., Jr.
Natwick, R. D.
Palmer, K. A.
Quilling, P. A.
Tweeten, J. B.

Mequon:

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Scholz, H. F. W.
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Merrill:

Bayer, L. J.
Bigalow, J. F.
Braun, W. E.
Janowiak, J. S.
Karabey, A. B.
Lane, F. C.
Lewinnek, Walter
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Middleton:

Domine, A. Z.
Fowler, P. H.
Heighway, T. F.
Leonard, T. A., Jr.
Schmidt, C. S.
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Milton:

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Davis, M. D.
Lyons, R. P.

Milton Junction:

Holmes, J. F.

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Albright, Howard
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Baron, J. J.
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Brennan, J. J.
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Bruns, W. T.
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Vaccaro, J. E.
Van Hecke, L. J.
Varga, Laszlo
Veit, Henry
Verdone, A. J.
Vinluan, A. M.
Wagner, Marvin
Wagner, P. C.
Waisbren, B. A.
Waisman, R. C.
Waldren, H. M.
Walker, J. A.
Walker, L. J.
Wall, Thomas
Wallner, E. F.
Walton, W. B.
Warner, R. C.
Warth, C. G.
Washburn, R. G
Watry, T. D.
Watson, H. J., Jr.
Watson, R. R.
Watts, Alice D.
Waxman, S. I.
Webb, W. C.
Weber, J. C.
Weber, J. E.
Weber, M. L.
Wegmann, G. H.
Weil, H. R.
Weingarten, Maxwell
Weinshel, L. R.
Weisel, Wilson
Weisenthal, C. L.
Weisfeld, S. G.
Weisfeldt, S. C.
Weller, R. R.
Wells, Marvin
Welsh, E. C.
Wepfer, J. F.
Werner, D. J.
Westley, William, Jr.
Whalen, G. E., Jr.
Wiesen, R. L.
Wild, J. P.
Wilets, J. B.
Wilets, J. C.
Williams, DeLore
Willson, D. M.
Wilson, S. D.
Winnik, D. E.
Wirthwein, C. L.
Wisniewski, P. P. Jr.
Wiviott, Wilbert
Wojcechowskyj, Stephen
Wolf, L. P.
Wolfe, C. W.
Woloschek, W. J.
Wolter, S. H.
Wong, V. J.
Woodward, G. S.

Worman, L. W.
Worsencraft, H. M.
Wyman, J. F.
Wynn, S. K.
Yatso, M. G.
Yellick, C. W.
Young, H. C.
Young, W. N.
Yount, L. J.
Zabors, T. E.
Zastrow, R. C.
Zautcke, A. B., Jr.
Zawodny, S. E.
Zeps, A. A.
Ziegler, C. T.
Ziehl, F. L.
Zillmer, Helen J.
Zimmermann, B. M.
Zubatsky, D. J.
Zuege, R. C.
Zupnik, G. R.

Mineral Point:
Hamlin, W. D.
Hohler, E. J.

Minocqua:
Ashe, H. S.
Flint, C. H.
Huber, G. W.
Smith, R. L.

Mishicot:
Nilles, J. E.

Mondovi:
Johnson, D. B.
Sharp, D. S.
Wright, W. E.

Monroe:
Barry, G. R.
Baumann, R. R.
Baumle, C. E.
Bear, N. E.
Brunkow, B. H.
Chandler, Arthur, Jr.
Eckstam, E. E.
Fencil, W. J.
Frantz, J. A.
Frantz, M. H.
Fuller, J. R.
Herzberger, E. E.
Irvin, J. M.
Jew, S. Q.
Kamstra, E.
Kindschi, L. G.
Kundert, F. W.
Maddix, B. L.
Miller, C. O.
Mings, D. E.
Murray, J. F.
Olson, M. J.
Rush, B. M.
Springer, D. W.
Staab, W. J., Jr.
Stiles, F. C.
Stormont, J. R.
Villacrez, J. A.
Watt, T. L.
Weeks, J. H.
Weir, J. R.
Wichser, R. F.
Witte, K. B.
Zach, R. G.
Zupanc, E. A.

Montello:
Inman, R. F.

Montfort:
Breier, H. P.

Mosinee:
Beglinger, H. F.
Hockett, A. J.

Mount Calvary:
Miller, J. F.

Mount Horeb:
Morrison, M. T.

Mukwonago:
Kern, E. E.
Rosenkranz, W. E.
Zarbock, F. M.
Zwisler, E. E.

Muscoda:
Ackerman, E. T.
Klockow, W. E.

Muskego:
Kelm, G. J.

Neenah:
Alt, T. H.
Anderson, G. R.
Arndt, G. W., Sr.
Beatty, S. R.
Brown, R. C.
Colgan, H. J.
Dedmon, R. E.
Douglas, R. F.
Geldner, Barbara
Geldner, M. M.
Graham, A. P.
Gursoy, E. Y.
Hardie, G. H.
Haselow, J. R.
Kennedy, W. F.
Kirchgeorg, Clemens
McCutcheon, Malcolm
Pansch, F. N.
Petersen, G. W.
Potter, G. L.
Regan, D. M.
Ryan, D. J.
Schaefer, Frederick
Schrang, E. A.
Schwab, R. L.
Smith, F. H.
Springer, V. G.
Suechting, R. L.
Talbot, A. E.
Varberg, W. R.

Nellisville:
Comstock, Elizabeth
Gungor, B. O.
Manz, K. F.
Rosekrans, M. C.
Rosekrans, Sarah D.
Thompson, T. N., Jr.

Nekoosa:
Pfeiffer, L. R.
Thompson, J. E.

New Berlin:
Clark, R. A.
De Vault, M. L.
Komar, R. R.
Schofield, Raymond
Selle, F. S.
Varma, S. D.

New Franken:
Looze, J. A.

New Glarus:
Marty, P. H.

New Holstein:
Engel, A. C.
Larme, F. P.

New Lisbon:
Koch, C. B
Weston, C. L.

New London:
Dernbach, G. P.
Monsted, J. W.
Pfeifer, F. J.
Schmallenberg, H. C.
Weber, J. W.

New Richmond:
Armstrong, J. H.
Craig, J. L.
Davis, R. R.
Drury, E. M.
Epley, O. H.
Weisbrod, L. W.

Niagara:
Maginn, Richard J.
McCormack, E. A.

Norwalk:
Allen, J. S.

Oak Creek:
Pizer, J. A.

Oconomowoc:
Claude, J. L.
Brown, J. F.
Driscoll, L. J.
Eisenman, T. S.
Epperson, D. P.
Frank, E. B.
Goral, T. J.
James, W. D.
Lameka, Peter
Matt, J. R.
Miller, G. D.
Mills, E. G.
Nammacher, T. H.
O'Hara, J. J.
Rogers, A. F.
Schroeder, T. A.
Schuele, D. T.
Schumacher, B. J.
Stemper, Irene T.
Theobald, P. B.
Weir, E. F.
Wilkinson, D. C.
Wilkinson, J. D.
Wilkinson, J. F.
Wilkinson, P. M.

Oconto:
Heinen, R. D.
Honish, John S.
Rogers, R. J.
Zantow, F. E.

Oconto Falls:
Culver, J. R.
Siefert, C. E
Strebe, K. L.
Theisen, J. K.

Omro:
Peck, D. D.
Schoenbechler, L. J.

Oregon:
Dukerschein, F. N.
Johnson, E. S.
Kellogg, L. S.

Orfordville:
McNair, E. R.

Osceola:
Inyart, J. R.
Simenstad, J. O.
Simenstad, L. O.
Stone, R. H.

Oshkosh:
Apell, M. G.
Becker, D. B., Jr.
Behnke, C. H.
Bitter, R. H.
Bowerman, C. I
Clark, W. E.
Connell, F. G.
Cummings, E F.
Danforth, H. J.
Emrich, P. S.
Graber, L. D.
Graiewski, S. J.
Greenwood, Ben. S.
Guenther, V. G.
Hahn, W. V.
Haines, M. C.
Hitselberger, J. F.
Hughes, J. B.
Isom, R. G.
Kivlin, T. M.
Koehler, A. G.
Kronzer, J. J.
Kuhn, R. V.
Kuhs, M. L.
Leibenson, S. J.
Leschke, John A.
McKenzie, J. R.
Meilicke, C. A.
Meli, J. V.
Monday, Harvey
Neubecker, R. D.
Payne, J. C.
Petersik, J. T.
Roberts, R. W.
Romberg, H. A.
Scheuermann, N. M.
Steen, M. H.
Stone, L. H.
Wagner, R. F.
Wagner, W. A.
Williams, E. B.
Winter, E. F.
Wolfgram, R. C.
Wright, E. N.
Zmolek, E. J.

Osseo:
Garber, B. G.
Knutson, Oscar
Leasum, R. N., Jr.

Owen:
Phillips, T. A.

Pardeeville:
Westcott, T. S.

Park Falls:
Enzinger, Josef
Eyvindsson, E. T.
Leahy, J. D.
Murphy, J. L.

Pell Lake:
Roenau, Elly A.

Peshtigo:
Barrette, Antoine
Blahnik, C. L.

Pewaukee:
Kelly, J. P.

Phelps:
Wolcott, R. R.

Phillips:
Niebauer, W. E.
Rens, J. L.

Plain:
Galarnyk, I. A.

Platteville:
Andrew, C. H.
Gurkow, H. J.
Moffett, J. L.
Nuland, S. J.
Steidinger, C. L.
Stuessy, M. F.

Plum City:
Docter, C. W.
Docter, J. C.

Plymouth:
Alvarez, R. J.
Brickbauer, A. J.
Dietsch, L. C.
Evers, R. H.
Mueller, J. F.
Steffan, L. J.
Weisse, H. A.

Portage:
Binnie, Helen A.
Bronson, F. H.
Cooney, R. T.
Grose, C. D.
Henney, C. W.
Henney, T. E.
Jones, W. W.
MacGregor, J. W.
Pavelsek, J. W.
Rueckert, R. R.
Saxe, J. J.
Taylor, S. F.
Taylor, W. A.
Tierney, E. F.
Villavicencio, C. A.

Port Edwards:
Glenn, E. C.

Port Washington:
Barr, A. H.
Corcoran, W. A., Jr.
Henkle, R. F.
Kauth, C. P.
Savage, G. F.
Wallestad, P. W.
Walsh, John F.

Pound:
Pelkey, R. B.

Poynette:
Dryer, R. B.
Focke, W. J.

Prairie du Chien:
Dessloch, E. M.
Epley, V. C.
Farrell, T. F.
Garrity, M. S.
Love, R. G.
Satter, O. E.
Shapiro, H. L.
Wong, J. R.

Prairie du Sac:
Bishop, P. R.
Carlson, H. P.
Zauft, G. W.

Prentice:
Thomas, G. L.

Prescott:
Laney, H. J.

Princeton:
Mueller, G. G.

Pulaski:
Shippy, V. J.

Racine:
Ageloff, Harry
Albino, J. M.
Alexander, A. C.
Bacon, G. A.
Barina, H. J.
Baumblatt, D. P.
Baylon, V. A.
Bein, Robert
Bennett, W. H.
Bliwas, Arnold
Brewer, G. W.
Bruton, J. T.
Buckley, W. E.
Burch, V. J.
Burke, Donald
Case, Q. C.
Christensen, F. C.
Christenson, C. W.
Coffey, B. T.
Constantine, C. E.
Cook, J. C.
Covell, K. W.
Currie, R. E
Cushman, S. M., Jr.
DeGroot, H. E.
Dorman, T. W.
Edwards, A. C.
Englander, S. M.
Faber, S. J.
Fazen, L. E., Jr.
Floch, L. J.
Fogle, R. J.
Fralich, J. C.
Gardetto, P. A.
Gass, H. I.
Geenen, J. E.
Gehring, C. A.
Gerol, A. Y.
Gillett, G. N.
Graf, A. E.
Grant, A. B.
Grinney, June L.
Grinney, L. R.
Hammes, J. R.
Hemmingsen, T. C.
Henken, W. F.
Herrmann, A. A.
Hilker, H. C.
Hilpert, F. M.
Hogan, J. H.
Hoggatt, J. E.
Jacobsen, A. J.
Jamieson, J. G.
Kaarakka, O. F.
Kehl, K. C.
Keland, H. B.
Kolmeier, K. H
Konnak, Wm. F.
Kreul, R. W.
Kreul, W. R.
Kurten, L. J.
Lauerman, E. P.
Leach, J. E.
Lehner, R. H.
Leitschuh, R. B.
Little, W. J., Jr.
MacVicar, E. L., Jr.
Madden, W. J.
Martinez-Larre, M.
Martinez, M. E.
Mayer, R. J.
McHale, J. A.
Miller, H. C.
Miller, P. L.
Miller, V. M.
Miller, W. C.
Minton, Richard
Nelson, M. W.
Newman, C. R.
Nickelsen, J. R.
Oberdorfer, C. E.
Olson, E. S.
Parker, M. G.
Petersen, J. J. G.
Pinkus, W. H.
Pope, F. W.
Postorino, J. D
Roth, W. C.
Rothenmaier, G. L.
Schacht, E. W.
Schacht, R. J.
Schatz, W. R.
Scheible, F. J.
Scheller, R. F.
Schenkenberg, Grace E.
Schleper, A. J.
Schroeder, H. T.
Schuster, Myron
Shack, J. B.
Simonsen, T. E.
Skow, G. D.
Skupniewicz, R. E.
Smith, L. W.
Smollen, W. J.
Smullen, G. H.
Steffen, Elizabeth A.
Stika, E. A.
Tomkiewicz, R. E.
von Jarchow, B. L.
Walters, H. G.
Williamson, W. H.
Wright, R. S.

Randolph:
Horvath, D. C.

Random Lake:
Russell, J. A.

Reedsburg:
Booher, J. A.
Hanko, J. E.
Knight, Robert G.
Pawlisch, O. V.
Rouse, J. J.
Simeon, R. G.
Stadel, E. V.

Reedsville:
Leering, Hendrik

Rhinelander:
Brown, J. F.
Bump, W. S.
Cline, Frances A.
Eggman, L. D.
Haug, Thomas M.
Johnson, A. G.
Litton, E. W.
Litton, M. A.
Mescher, T. J.
Nevin, Ismail Nik
Osborne, R. R.
Pratt, G. F.
Rosemeyer, O. G.
Schiek, I. E.
Schlek, I. E., Jr.
Simmons, W. K.
Thuerer, G. R.
Wright, Marvin

Rice Lake:
Cotts, L. R.
Eidsmoe, N. A.
Gillespie, M. E.
Henningsen, John
Hoyer, J. K.
Kristensen, L. A.
Kundel, R. R.
Maser, J. F.
Rydell, O. E.
Rydell, W. B.

Richfield:
Zintek, A. R.

Richland Center:
Edwards, R. W.
Edwards, W. C.
Glise, Roy C., Jr.
Housner, R. E.
Kelertas, J. H.
Meyer, K. H.
Parke, George, Jr.
Pippin, L. M.
Spear, Jack
Taft, D. J.
Tydrich, J. J.

Ripon:
Bachus, A. C.
Dittmer, O. A.
Johnson, J. M.
La Ham, J. T.
Lofdahl, S., Jr.
Pelton, R. S.
Schuler, W. H.

River Falls:
Dohnalek, D. W.
Grassl, F. O.
Gutzler, P. H.
Hammer, R. M.
Haskins, P. S.
Orlow, W. O.

Rosholt:
Benn, V. A.

St. Croix Falls:
Ericksen, D. M.
Nelson, L. K.
Olson, L. L.
Riegel, F. B.
Riegel, J. A.
Wegner, M. E.

St. Nazianz:
Foley, M. E.

Sauk City:
Bachhuber, H. A.
Kraus, E. T. F.
Walsh, T. W.

Schofield:
Olson, M. H.

Seymour:
Groendahl, R. C.
Hittner, V. J.
Sieb, L. H.

Sharon:
Schrock J. B., Jr.

Shawano:
Arvold, D. S.
Bergmann, F. T.
Cantwell, A. A.
Cantwell, R. C.
Coan, W. A.
Jeffries, Donald A.
Logemann, R. L.
Schulz, D. W.
Sebesta, A. J.

Sheboygan:
Ashby, A. O.
Bassewitz, P. P.
Batzner, D. J.
Bock, A. B.
Braun, N. P.
Bringe, J. W.
Cinelis, Ann A.
Dick, H. J.
Eckardt, B. F.
Graf, C. A.
Gruenewald, Ludwig
Heinz, H. N.
Hidde, F. G.
Hildebrand, G. J.
Hildebrand, J. F.
Hoon, J. R.
Houfek, E. E.
Huibregtse, W. G.
Jaeck, J. L.
Jochimsen, E. H.
Johnson, R. C.
Jumes, M. G.
Keller, R. A.
Kolb, F. K.
Kovacic, J. F.
Marsho, B. S.
Mason, P. B.
McRoberts, J. W.
Michael, J. D
Moir, Jane M.
Moir, W. W.
Mooney, F. L.
Mueller, H. A.
Nause, F. A.
Nause, F. P.
O'Donnell, S. P.
Pauly, L. F.
Pauly, R. C.
Pointer, R. W.
Quinn, G. A.
Rammer, M. A., Jr.
Reinemann, J. M.
Schlichting, J. E.
Schott, E. G.
Schroeder, I. L.
Sciarra, P. A.
Senty, R. M.
Simonson, L. M.
Simpson, R. M.
Stewart, O. K.
Tasche, C. T.
Tasche, J. A.
Tasche, L. W.
Tompsett, A. C., Jr.
Van Driest, J. J.
Weber, C. J.
Windsor, R. B.
Winsauer, H. J.
Wood, R. A.

Sheboygan Falls:
Hansen, H. J.
Leighton, F. A.
Weygandt, J. L.

Shell Lake:
Flogstad, Duane
Moen, D. V.
Welter, D. J.

Shiocton:
La Croix, G. M.

Shorewood:
Gager, W. E.
Vlazny, F. J.

Shullsburg:
Hoesley, H. F.

Silver Lake:
De Witt, C. A.

Siren:
Sun, K. C.

Slinger:
Prefontaine, K. F.

Soldiers Grove:
Sannes, W. A.

South Milwaukee:
Adali, I. S.
Barrett, D. A., II
Crigler, R. R.
Flanerty, G. S.
Grimm, J. J.
McFadden, Wayne
Murphy, G. V.
Oberfeld, H. H.
O'Leary, W. J.
Roob, D. M.
Schwartz, H. L.
Spencer, G. N.
Thelsen, C. E.
Turgal, Valerio
Zahl, W. H.

South Wayne:
Creasy, L. E.

Sparta:
Albrecht, P. G.
Beebe, D. C.
Beebe, S. D.
Brown, J. D.
Harris, A. J.
Lukasek, E. O.
Williams, H. H., Jr.

Spooner:
Goetsch, F. H.
Matzke, R. W.
Olson, L. J.

Spring Green:
Kempthorne, G. C.

Spring Valley:
Meyer, R. J.

Stanley:
La Breche, J. J.
Mathwig, R. J.
Overgard, A. W.
Sallis, D. A.

Stevens Point:
Anderson, G. H.
Anderson, H. A.
Benn, H. P.
Bickford, R. H.
Dunn, A. G.
Eckberg, R. A.
Erickson, J. R.
Gehin, F. E.
Gramowski, W. A.
Iber, F. C.
Kennedy, J. T.
Kohn, A. M.
Litzow, J. A.
Milano, Angelo
Miller, S. R.
Reichardt, F. W.
Rice, M. G.
Rifleman, R. H.
Riordan, J. F.
Schierl, A. G.
Sciarrone, Francesco
Sevenich, J. R.
Sheehan, W. C.
Slater, R. H.
Sowka, A. J.
Sowka, P. N.

Stockbridge:
Knauf, J. A.

Stone Lake:
Marlewski, C. R.

Stoughton:
Hermundstad, O. A.
Nelson, D. L.
Nordholm, V. W.
Peterson, R. K.
Schammel, F. M.
Schoenbeck, P. J.
Schoenbeck, R. F.

Stratford:
Kroeplin, F. C.

Sturgeon Bay:
Beck, J. G.
Brook, J. J., Jr.
Evenson, R. G.
Grota, H. D.
Hobson, W. S.
Sheets, W. G.
Wagener, N. R.

Sun Prairie:
Behrend, J. F.
Grab, J. A.
Hahn, M. F.
Nelson, E. J.
Russell, W. T.
Syty, Joseph

Superior:
Anderson, R. T.
Doyle, T. J.
Ekblad, V. E.
Finn, Milton
Fruehauf, R. P.
Giesen, Conrad W.
Johnson, F. G., Jr.
Knights, J. A.
Krahl, Enzo
Lavine, I. H.
Lavine, M. M.
Mann, Robert
Mataczynski, R. R.
McGill, J. W.
McGinnis, J. P.
Picard, C. J.
Rosin, L. R.
Scott, C. M.
Sellers, R. L.
Sincock, H. A.
Stack, E. G., Jr.
Thompson, R. T.

Suring:
Sandgren, G. R.

Sussex:
Stein, R. W
Van Valin, E. C.

Theresa:
Langenfeld, G. P.

Thiensville:
Elbe, T. D.
Herman, Murray
Kim, K. S.
Levy, E. S.
Montgomery, E. G., Jr.

Thorp:
Connolly, James
Neis, F. P.

Tigerton:
Heise, L. F.

Tomah:
Konicek, R. G.
Kozarek, C. E.
Landmann, G. A.
Mubarak, J. S.
Ryan, C. J.

Tomahawk:
Baker, R. G.
Bugarin, N. L.
Francisco, Orlando
Henderson, R. J.
Jarvis, D. F.
McCormick, W. C.

Turtle Lake:
Halberg, A. C.

Twin Lakes:
Slocumb, C. O.

Two Rivers:
Kaner, S. L.
Kozelka, A. W.
Kuljis, D. A.
Martin, R. E.
Weld, S. L.
Zlatnik, A. P.
Zlatnik, P. A.

Union Grove:
Haedike, W. D.
Lawrence, P. J.
Schulz, G. J.
White, E. F.

Verona:
Noll, D. J.
Pellett, J. R.
Stuesser, G. J.

Viroqua:
Ender, C. A.
Gulbrandsen, L. F.
Kuehn, A. E.
Oppert, H. E.
Starr, R. A.
Vig, D. E.
Vig, De Verne W.
Vig, E. N.

Wabeno:
Tenley, O S.

Wales:
Francis, R. J.

Walworth:
Bingol, O. G.
Bruhn, I. J.
Coon, W. W.
Hansen, D. R.
Kroyer, T. J.

Washburn:
Guzzo, Harold
Telford, J. G.

Washington Island:
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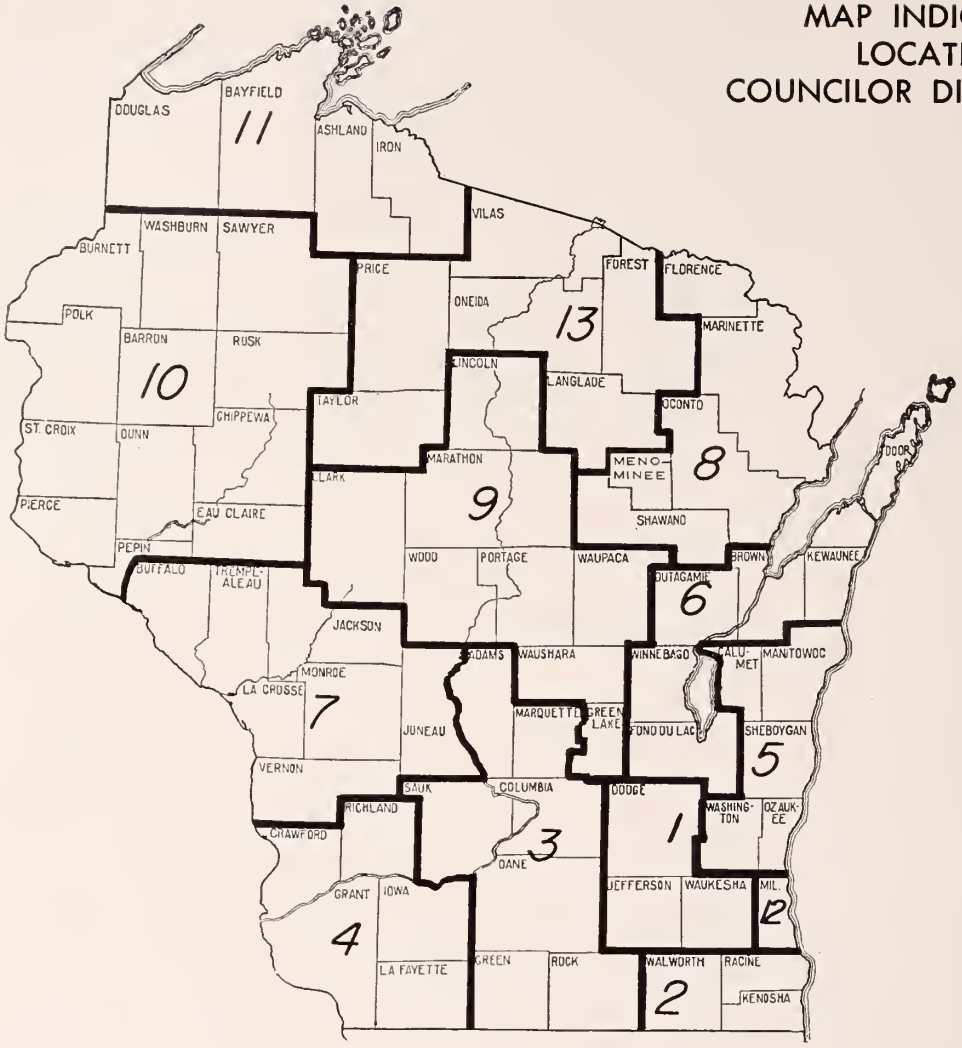
WORK WEEK OF HEALTH PAPERS PUBLISHED

The September 1966 issue of *Industrial Medicine & Surgery* featured three papers which were presented at the Fourth Annual Wisconsin Work Week of Health, February 14–18, 1966, sponsored by the State Medical Society of Wisconsin.

The papers published were: "Occupational and Industrial Health: A Look Toward the Future" by Henry F. Howe, MD, director, Department of Occupational Health, American Medical Association; "The Push-Button Era of Medicine" by James Z. Appel, MD, immediate past president of the AMA; and "Increased Leisure Time—Its Effect Upon Health" by Lawrence L. Suhm, director, Center for Leisure Resources Development, University of Wisconsin, Madison.

MAP INDICATING LOCATION OF COUNCILOR DISTRICTS



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FOURTH: Crawford, Grant, Iowa, Lafayette and Richland County Societies. H. W. Carey, M.D., 257 Madison Street, Lancaster 53813, (1967).

FIFTH: Calumet, Manitowoc, Sheboygan, Washington and Ozaukee County Societies. P. B. Blanchard, M.D., 204 North Washington Avenue, Cedarburg 53012, (1967).

SIXTH: Brown, Door–Kewaunee, Fond du Lac, Outagamie and Winnebago County Societies. James A. Sisk, M.D., 566–5th Street, Fond du Lac 54935, (1967); J. E. Dettmann, M.D., 519 South Monroe Avenue, Green Bay 54301, (1968).

SEVENTH: Juneau, La Crosse, Monroe, Trempealeau–Jackson–Buffalo and Vernon County Societies. J. C. Fox, M.D. (Chairman), 212 South Eleventh Street, La Crosse 54601, (1968).

EIGHTH: Marinette–Florence, Oconto and Shawano County Societies. J. W. Boren, Jr., M.D., 1510 Main Street, Marinette 54143, (1968).

NINTH: Clark, Green Lake–Waushara, Lincoln, Marathon, Portage, Waupaca and Wood County Societies. E. P. Ludwig, M.D., 400 Strollers Lane, Wausau 54401, (1968).

TENTH: Barron–Washburn–Sawyer–Burnett, Chippewa, Eau Claire–Dunn–Pepin, Pierce–St. Croix, Polk and Rusk County Societies. W. R. Manz, M.D., 204 East Grand Avenue, Eau Claire 54701, (1968).

ELEVENTH: Ashland–Bayfield–Iron and Douglas County Societies. C. A. Grand, M.D., Masonic Temple Building, Ashland 54806, (1969).

TWELFTH: The Medical Society of Milwaukee County. L. J. Van Hecke, M.D., 161 West Wisconsin Avenue, Milwaukee 53203, (1969); W. J. Houghton, M.D., 2943 North Oakland Avenue, Milwaukee 53211, (1969); W. J. Egan, M.D., 720 North Jefferson Street, Milwaukee 53202, (1967); S. L. Chojnacki, M.D., 3122 South Thirteenth Street, Milwaukee 53215, (1968); S. W. Hollenbeck, M.D., 2650 West Fond du Lac Avenue, Milwaukee 53206, (1968).

THIRTEENTH: Forest, Langlade, Oneida–Vilas and Price–Taylor County Societies. Marvin Wright, M.D., 1020 Kabel Avenue, Rhinelander 54501, (1968).

PAST PRESIDENT _____ J. H. Houghton, M.D.
Wisconsin Dells 53965, Box 325

DELEGATES TO THE AMERICAN MEDICAL ASSOCIATION

W. B. Hildebrand, M.D. (1967) _____ Menasha 54952
59 Racine Street

R. E. Galasinski, M.D. (1967) _____ Milwaukee 53215
3333 South 27th Street

John M. Bell, M.D. (1968) _____ Marinette 54143
516 Houston Street

E. L. Bernhart, M.D. (1968) _____ Milwaukee 53210
2714 West Burleigh Street

Alternates

N. A. Hill, M.D. (1967) _____ Madison 53703
304 West Washington Avenue

George Collentine, Jr., M.D. (1967) _____ Milwaukee
53202, 2266 North Prospect Avenue

J. C. Fox, M.D. (1968) _____ La Crosse 54601
212 South Eleventh Street

C. J. Picard, M.D. (1968) _____ Superior 54880
425 Twenty-first Avenue East

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* Map indicating location of councilor districts, page 76.

Note: Officers, councilors, delegates, and members of Standing Committees are elected at the Annual Meeting in May. Dates in parentheses indicate expiration of term of office.

Standing Committees—1966-1967

State Medical Society of Wisconsin

COMMITTEE ON CANCER

(Composed of a member from each Councilor District)

G. A. Smiley, M.D.
Chairman

G. A. Smiley, M.D. (1968) Delavan 53115
Chairman 107 North Third Street
R. C. Glise, M.D. (1968) Richland Center 53581
Vice-Chairman 890 E. Kinder Street
Raymond J. Rogers, M.D. (1967) Oconto 54153
R. 1, Box 49
John K. Scott, M.D. (1967) Madison 53711
1605 Monroe Street
G. H. Williams, M.D. (1967) Marshfield 54449
650 South Central Avenue
G. I. Uhrich, M.D. (1968) La Crosse 54601
212 South Eleventh Street
Ralph C. Frank, M.D. (1968) Eau Claire 54701
550 North Dewey Street
J. J. Gramling, Jr., M.D. (1968) Milwaukee 53202
324 East Wisconsin Avenue
J. F. Brown, M.D. (1968) Rhinelander 54501
1020 Kabel Avenue
J. R. Hoon, M.D. (1969) Sheboygan 53081
1011 North 8th Street
G. Daniel Miller, M.D. (1969) Oconomowoc 53066
37880 Forrest Drive
F. L. Schaefer, M.D. (1969) Menasha 54952
59 Racine Street
Enzo Krahl, M.D. (1969) Superior 54880
3600 Tower Avenue

COMMITTEE ON GRIEVANCES

E. W. Mason, M.D.
Chairman

E. W. Mason, M.D. (1968) Milwaukee 53202
Chairman 324 East Wisconsin Ave.
J. D. Leahy, M.D. (1969) Park Falls 54552
Vice-Chairman 170 Fourth Avenue North
C. E. Wall, M.D. (1967) Manitowoc 54220
904A S. Eighth Street
D. W. Dailey, M.D. (1967) Elcho 54428
O. G. Moland, M.D. (1967) Augusta 54722
E. D. Sorenson, M.D. (1968) Elkhorn 53121
104 South Wisconsin St.
R. W. Mason, M.D. (1968) Marshfield 54449
650 South Central Avenue
Donald R. Griffith (1969) Eau Claire 54701
314 Grand Ave. East
M. F. Huth, M.D. (1969) Baraboo 53913
203 Fourth Street

COMMISSION ON PUBLIC RELATIONS AND COMMUNICATIONS

J. S. Devitt, M.D.
Chairman

J. S. Devitt, M.D. (1967) Milwaukee 53202
Chairman 2243 North Prospect Ave.
R. J. Botham, M.D. (1969) Madison 53715
Vice-Chairman 1313 Fish Hatchery Road
Louis Olsman, M.D. (1967) Kenosha 53140
625 57th Street
C. A. Olson, M.D. (1967) Baldwin 54002
C. J. Picard, M.D. (1968) Superior 54880
425—21st Avenue, East
R. G. Hansel, M.D. (1968) Baraboo 53913
407 Oak Street
R. R. Rueckert, M.D. (1968) Portage 53901
143 East Cook Street
R. B. Bourne, M.D. (1969) Milwaukee 53202
208 East Wisconsin Ave.
Vacancy

SUPPORT YOUR FOUNDATION

It is your opportunity to give financial assistance to the charitable, educational and scientific aspects of medicine as they relate to the health and well-being of the people of Wisconsin. Gifts may take a number of forms such as cash, life insurance, securities, land, books, instruments, stamp and coin collections, works of art and other artifacts. Some physicians are making the Foundation a beneficiary of their wills. In any event, all contributions to the Foundation are deductible for income tax purposes. Checks may be made out to: CES Foundation, and sent to CES Foundation, State Medical Society of Wisconsin, Box 1109, Madison, Wisconsin 53701.

COMMISSION ON PUBLIC POLICY

W. T. Russell, M.D.
Chairman

W. T. Russell, M.D. (1971) _____ Sun Prairie 53590
Chairman 215 East Main Street
C. F. Broderick, M.D. (1968) _ Wisconsin Dells 53965
Vice-Chairman Box 325
Earl C. Quackenbush, M.D. (1967) __ Hartford 53027
14 North Main Street
L. W. Schrank, M.D. (1967) _____ Waupun 53963
200 East Main Street
T. E. Henney, M.D. (1967) _____ Portage 53901
310 West Conant Street
J. M. Lubitz, M.D. (1969) _____ Brookfield 53005
1950 Alverno Drive
L. J. Kurten, M.D. (1970) _____ Racine 53404
2405 Northwestern Ave.

Section Representatives

K. L. Siebecker, Jr., M.D. (1967) ___ Madison 53706
Anesthesiology 1300 University Ave.
H. A. Peters, M.D. (1967) _____ Madison 53706
Neurology & Psychiatry 1300 University Ave.
J. V. Bolger, Jr., M.D. (1967) ____ Waukesha 53186
Ophthalmology 102 E. Main Street
Vacancy
Otolaryngology
J. S. Veum, M.D. (1967) _____ Appleton 54911
Pediatrics 401 N. Oneida Street
R. L. Gilbert, M.D. (1968) _____ La Crosse 54601
Internal Medicine 1707 Main Street
J. B. Durst, M.D. (1968) _____ La Crosse 54601
Obstetrics & Gynecology 1707 Main Street
P. K. Odland, M.D. (1968) _____ Janesville 53545
Orthopedics 305 Court Street
S. A. Freitag, M.D. (1968) _____ Janesville 53545
Urology 500 W. Milwaukee Street
A. D. Anderson, M.D. (1968) _____ Madison 53703
Surgery 2 West Gorham Street
J. L. Teresi, M.D. (1969) _____ Brookfield 53005
Pathology 14760 Virginia
Lyle Edelblute, M.D. (1969) _____ Green Bay 54301
Radiology Bellin Memorial Hospital
Donald S. Schuster, M.D. (1969) ___ Madison 53705
Dermatology 222 North Midvale Blvd.
N. G. Bauch, M.D. (1969) _____ Milwaukee 53222
General Practice 3102 North 78th St.
J. A. Van Susteren, M.D. (1969) __ La Crosse 54601
Public Health 250 Mormon Coulee Rd.
Vacancy
Medical Faculties
President Drew, *ex officio*
President-elect Kief, *ex officio*
Secretary Crownhart, *ex officio*

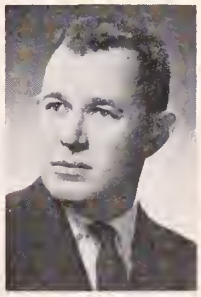
COMMISSION ON SCIENTIFIC MEDICINE

J. K. Curtis, M.D.
Chairman

J. K. Curtis, M.D. (1967) _____ Madison 53705
Chairman 2500 Overlook Terrace
W. T. Russell, M.D. (1967) _____ Sun Prairie 53590
215 East Main Street
T. V. Geppert, M.D. (1968) _____ Madison 53715
1313 Fish Hatchery Road
Ovid Meyer, M.D. (1968) _____ Madison 53706
1300 University Avenue
Edgar S. Gordon, M.D. (1969) _____ Madison 53706
1300 University Avenue
Albert Martin, M.D. (1969) _____ Milwaukee 53202
324 E. Wisconsin Avenue
J. A. Killins, M.D. (1970) _____ Green Bay 54303
123 North Military Avenue
R. A. Starr, M.D. (1970) _____ Viroqua 54665
318 South Main Street
A. V. Pisciotta, M.D. (1971) _____ Milwaukee 53233
545 North 15th St.
Ben R. Lawton, M.D. (1971) _____ Marshfield 54449
650 South Central Ave.
Victor S. Falk, Jr., M.D., Medical Editor, *Wisconsin Medical Journal* _____ Edgerton 53534
Ex officio 5 West Rollin Street
G. A. Kerrigan, M.D., Dean, Marquette University School of Medicine _____ Milwaukee 53233
Ex officio 561 North 15th Street
Peter L. Eichman, M.D., Dean, University of Wisconsin Medical School _____ Madison 53706
Ex officio 1300 University Avenue

COMMISSION ON HOSPITAL RELATIONS AND MEDICAL EDUCATION

G. B. Murphy, Jr., M.D.
Chairman



G. B. Murphy, Jr., M.D. (1967) ___ La Crosse 54601
Chairman 1836 South Avenue
Dale V. Moen, M.D. (1967) _____ Shell Lake 54871
G. W. Hilliard, M.D. (1967) _____ Milwaukee 53212
425 West North Avenue
R. S. Galgano, M.D. (1968) _____ Delavan 53115
610 Walworth Avenue
Vacancy (1968)
A. J. Richtsmeier, M.D. (1968) _____ Madison 53703
110 East Main Street

(continued on next page)

S. L. Henke, M.D. (1969) Eau Claire 54701
314 Grand Avenue, East
P. C. Dietz, M.D. (1969) La Crosse 54601
1020 Market Street
Donald E. Koepke, M.D. (1969) Milwaukee 53202
324 East Wisconsin Ave.
Peter L. Eichman, M.D., Dean, University of Wisconsin Medical School Madison 53706
Ex officio 1300 University Avenue
G. A. Kerrigan, M.D., Dean, Marquette University School of Medicine Milwaukee 53233
Ex officio 561 North Fifteenth Street

* * *

ADVISORY COMMITTEE TO WOMAN'S AUXILIARY

Chairman of the Council, Chairman
Immediate Past President
President
President-elect
Secretary

COUNCIL COMMITTEES

Appointments to the following committees are made by the chairman of the Council at the time of the Annual Meeting in May.

Committees of the Council (composed of members of Council):

Economic Medicine
Executive
Finance
Planning
Scientific Medicine

Council Committees:

Ad Hoc
Disaster Medical Care
Commission on Medical Care Plans
Commission on State Departments
Editorial Board
Military Medical Service
Past Presidents

COMPONENT COUNCIL COMMITTEES 1966–1967

(Appointed by the Chairman of the Council and composed of members of the Council)

EXECUTIVE COMMITTEE

James C. Fox, M.D. La Crosse 54601
Chairman of the Council 212 South 11th Street
E. J. Nordby, M.D. Madison 53705
Vice-chairman of the Council 2715 Marshall Court
M. D. Davis, M.D. Milton 53563
Chairman, Planning 309 College St.
W. D. James, M.D. Oconomowoc 53066
Chairman, Finance 340 Summit Avenue
L. J. Van Hecke, M.D. Milwaukee 53210
Chairman, Scientific Medicine
6001 West Center Street
P. B. Blanchard, M.D. Cedarburg 53012
Chairman, Economic Medicine
204 North Washington
Frank E. Drew, M.D., president Milwaukee 53202
Chairman
Ex officio 425 East Wisconsin Ave.
H. J. Kief, M.D., president-elect
Fond du Lac 54935
Ex officio 505 East Division
J. H. Houghton, M.D., past president
Wisconsin Dells 53965
Ex officio Box 325

SCIENTIFIC MEDICINE

L. J. Van Hecke, M.D. Milwaukee 53210
Chairman 6001 West Center Street
J. H. Houghton, M.D. Wisconsin Dells 53965
Box 325
C. W. Stoops, M.D. Madison 53703
110 East Main Street
W. J. Houghton, M.D. Milwaukee 53211
2943 North Oakland Avenue
S. W. Hollenbeck, M.D. Milwaukee 53206
2650 West Fond du Lac Avenue
James C. Fox, M.D. La Crosse 54601
Chairman of the Council
Ex officio 212 South 11th Street

ECONOMIC MEDICINE

P. B. Blanchard, M.D. Cedarburg 53012
Chairman 204 North Washington Avenue
G. J. Schulz, M.D. Union Grove 53182
722 15th Avenue
Marvin Wright, M.D. Rhinelander 54501
1020 Kabel Avenue
James A. Sisk, M.D. Fond du Lac 54935
566 Fifth Street
H. W. Carey, M.D. Lancaster 53813
257 Madison Street
James C. Fox, M.D. La Crosse 54601
Chairman of the Council
Ex officio 212 South 11th Street

PLANNING

M. D. Davis, M.D. Milton 53563
Chairman 309 College St.
Walton R. Manz, M.D. Eau Claire 54701
204 East Grand Avenue
C. A. Grand, M.D. Ashland 54806
Masonic Temple Building
W. J. Egan, M.D. Milwaukee 53202
720 North Jefferson Street
E. P. Ludwig, M.D. Wausau 54401
400 Strollers Lane
James C. Fox, M.D. La Crosse 54601
Chairman of the Council
Ex officio 212 South 11th Street

FINANCE

W. D. James, M.D. (1967) Oconomowoc 53066
Chairman 340 Summit Avenue
Marvin Wright, M.D. (1967) Rhinelander 54501
1020 Kabel Avenue
J. W. Boren, Jr., M.D. (1968) Marinette 54143
1510 Main Street
S. L. Chojnacki, M.D. (1968) Milwaukee 53215
3122 South 13th Street
E. J. Nordby, M.D. (1969) Madison 53705
2715 Marshall Ct.
J. E. Dettmann, M.D. (1969) Green Bay 54301
519 South Monroe Ave.
F. L. Weston, M.D., treasurer Madison 53703
Ex officio One South Pinckney Street
James C. Fox, M.D. La Crosse 54601
Chairman of the Council
Ex officio 212 South 11th St.

SMS COUNCIL COMMITTEES 1966–1967

(Appointed by the Chairman of the Council and composed of members of the State Medical Society)

DISASTER MEDICAL CARE

J. S. Wier, M.D._____Fond du Lac 54935
Chairman 80 Sheboygan Street
E. A. Bachhuber, M.D._____Milwaukee 53233
561 North 15th Street
S. J. Graiewski, M.D._____Oshkosh 54901
155 North Sawyer
D. L. Williams, M.D._____Madison 53703
30 South Henry Street
Harold Cook, M.D._____Milwaukee 53226
8700 W. Wisconsin Avenue
E. P. Rohde, M.D._____Galesville 54630

EDITORIAL BOARD

D. W. Ovitt, M.D._____Milwaukee 53202
2266 North Prospect Avenue
M. F. Huth, M.D._____Baraboo 53913
203 Fourth Street
L. G. Kindschi, M.D._____Monroe 53566
1770 13th Street
G. A. Cooper, M.D._____Madison 53703
110 E. Main Street
M. C. F. Lindert, M.D._____Milwaukee 53213
6745 West Wells Street
V. S. Falk, M.D., Medical Editor___Edgerton 53534
Chairman 5 West Rollin Street
Ex Officio

MILITARY MEDICAL SERVICE

F. L. Weston, M.D._____Madison 53703
Chairman 1 So. Pinckney Street
J. M. Sullivan, M.D._____Milwaukee 53203
161 W. Wisconsin Avenue
M. H. Steen, M.D._____Oshkosh 54901
421 Jefferson Street
O. G. Moland, M.D._____Augusta 54722
D. S. Arvold, M.D._____Shawano 54166
117 E. Green Bay Street

COMMISSION ON MEDICAL CARE PLANS

E. M. Dessloch, M.D. (1967)_Prairie du Chien 53821
Chairman Medical Park
Robert Krohn, M.D. (1968)_Black River Falls 54615
Vice-chairman Krohn Clinic
G. W. Carlson, M.D. (1967)_____Appleton 54911
103 West College Ave.
D. N. Goldstein, M.D. (1967)_____Kenosha 53140
723 58th Street
A. W. Hilker, M.D. (1967)_____Eau Claire 54701
314 Grand Avenue East
P. B. Mason, M.D. (1967)_____Sheboygan 53081
1011 No. 8th Street
E. J. Nordby, M.D. (1967)_____Madison 53705
2715 Marshall Court
L. O. Simenstad, M.D. (1967)_____Osceola 54020
195 Hammond Street
A. H. Stahmer, M.D. (1967)_____Wausau 54401
404 South Third Avenue
Howard Mauthe, M.D. (1967)__Fond du Lac 54935
340 Sheboygan Street
W. T. Casper, M.D. (1968)_____Milwaukee 53216
4222 West Capitol Drive
M. D. Davis, M.D. (1968)_____Milton 53563
309 College Street
A. J. McCarey, M.D. (1968)_____Green Bay 54301
610 Northern Bldg.
J. T. Sprague, M.D. (1968)_____Madison 53703
109 E. Johnson Street
F. H. Wolf, M.D. (1968)_____La Crosse 54601
419–421 Main Street
Milton Finn, M.D. (1969)_____Superior 54880
3600 Tower Avenue
Donald A. Jeffries, M.D. (1969)____Shawano 54166
117 E. Green Bay St.
Charles Benkendorf, M.D. (1969)__Green Bay 54301
408 St. Francis Drive
T. J. Doyle, M.D. (1969)_____Superior 54880
1507 Tower Ave.
J. H. Houghton, M.D. (1969)_Wisconsin Dells 53965
Box 325
R. A. Sievert, M.D. (1969)_____Madison 53715
925 Mound St.
W. E. Wright, M.D. (1969)_____Mondovi 54755
221 North Eau Claire St.
R. M. Moore, M.D. (1969)_____Frederic 54837
President Drew
President-elect Kief

COMMISSION ON STATE DEPARTMENTS

T. W. Tormey, Jr., M.D._____Madison 53703
Chairman 16 No. Carroll Street
W. J. Egan, M.D._____Milwaukee 53202
Vice-chairman 720 North Jefferson Street

Division Chairmen:

J. J. Suits, M.D._____Marshfield
Handicapped Children 650 South Central Avenue
Vacancy
Aging
John Evrard, M.D._____Milwaukee 53202
Maternal & Child Welfare
208 East Wisconsin Avenue
A. A. Lorenz, M.D._____Eau Claire 54701
Nervous & Mental Diseases 605 Walker Avenue
H. W. Carey, M.D._____Lancaster 53813
Public Assistance 257 No. Madison Street
J. L. Weygandt, M.D._____Sheboygan Falls 53085
Safe Transportation 716 Monroe Street
H. A. Anderson, M.D._____Stevens Point 54481
Chest Diseases River Pines Sanatorium
J. C. H. Russell, M.D._____Fort Atkinson 53538
School Health 38 South Water Street
Meyer S. Fox, M.D._____Milwaukee 53233
Visual & Hearing Defects
2040 W. Wisconsin Avenue
Paul Dudenhoefer, M.D._____Milwaukee 53213
Rehabilitation 6541 Washington Circle

AD HOC COMMITTEE

Karl H. Beck, M.D._____Wauwatosa 53213
949 Glenview Avenue
Maurice Hardgrove, M.D._____Milwaukee 53202
208 E. Wisconsin Avenue
N. A. McGreane, M.D._____Darlington 53530
128 E. Ann Street
Two vacancies

PAST PRESIDENTS

J. H. Houghton, M.D._____Wisconsin Dells 53965
Chairman Box 325
W. P. Curran, M.D._____Antigo 54409
Box 420
W. J. Egan, M.D._____Milwaukee 53202
720 North Jefferson Street
M. A. McGarty, M.D._____La Crosse 54601
509 State Bank Building
R. P. Sproule, M.D._____Milwaukee 53202
1024 East State Street
Gunnar Gundersen, M.D._____La Crosse 54601
1836 South Avenue
W. D. Stovall, M.D._____Madison 53705
Two Thorstrand Road

(continued on next page)

K. H. Doege, M.D._____Marshfield 54449
650 South Central Avenue
J. C. Griffith, M.D._____Milwaukee 53202
2243 North Prospect Avenue
H. K. Tenney, M.D._____Madison 53703
1 South Pinckney Street
A. J. McCarey, M.D._____Green Bay 54301
610 Northern Building
E. L. Bernhart, M.D._____Milwaukee 53210
2714 West Burleigh Street
L. O. Simenstad, M.D._____Osceola 54020
195 Hammond Street

H. E. Kasten, M.D._____Beloit 53511
419 Pleasant Street
W. B. Hildebrand, M.D._____Menasha 54952
59 Racine Street
E. D. Sorenson, M.D._____Elkhorn 53121
104 South Wisconsin Street
L. H. Lokvam, M.D._____Kenosha 53140
723—58th Street
N. A. Hill, M.D._____Madison 53703
304 West Washington Avenue

OFFICERS OF SCIENTIFIC SECTIONS OF THE STATE MEDICAL SOCIETY

SECTION ON ANESTHESIOLOGY
President _____ Fred D. Cook, Green Bay
Secretary _____ Ruth A. Stoerker, Madison
Delegate _____ Harry Thimke, Eau Claire
Alternate _____ David Noll, Verona

SECTION ON DERMATOLOGY
President _____ G. O. Stubenrauch, Milwaukee
Secretary _____ Robert Pittelkow, Milwaukee
Delegate _____ Joel Taxman, Milwaukee
Alternate _____ G. O. Stubenrauch, Milwaukee

SECTION ON GENERAL PRACTICE
President _____ C. A. Grand, Ashland
Secretary _____ Donald Heyrman, Menomonee Falls
Delegate _____ R. R. Richards, Eau Claire
Alternate _____ Eugene Kay, Milwaukee

SECTION ON INTERNAL MEDICINE
President _____ John H. Wishart, Eau Claire
Secretary _____ James W. Manier, Marshfield
Delegate _____ John M. Irvin, Monroe
Alternate _____ James A. Means, Milwaukee

SECTION ON MEDICAL FACULTIES
Delegate _____ O. O. Meyer, Madison
Alternate _____ E. A. Bachhuber, Milwaukee

SECTION ON NEUROLOGY AND PSYCHIATRY
President _____ B. Cullen Burris, Milwaukee
Secretary _____ C. W. Osgood, Wauwatosa
Treasurer _____ Albert Lorenz, Eau Claire
Delegate _____ Joseph G. Brown, Madison
Alternate _____ B. Cullen Burris, Milwaukee

SECTION ON OBSTETRICS AND GYNECOLOGY
President _____ R. E. Whitsitt, Madison
Secretary _____ Richard Brown, Eau Claire
Delegate _____ William Madden, Racine
Alternate _____ R. E. Whitsitt, Madison

SECTION ON OPHTHALMOLOGY
President _____ J. V. Bolger, Jr., Waukesha
Secretary _____ William H. Bennett, Racine
Delegate _____ Arthur Kissling, Milwaukee
Alternate _____ C. F. Schmidt, La Crosse

SECTION ON ORTHOPEDICS
President _____ Charles W. Christenson, Racine
Secretary _____ Marvin Nelson, Racine
Delegate _____ Peter Golden, Madison
Alternate _____ C. Hugh Hickey, Jr., Milwaukee

SECTION ON OTOLARYNGOLOGY
President _____ P. A. Sciarra, Sheboygan
Secretary _____ Maxine Bennett, Madison
Delegate _____ Watson B. Larkin, Eau Claire
Alternate _____ John K. Scott, Madison

SECTION ON PATHOLOGY
President _____ Philip G. Piper, Madison
Secretary _____ D. J. La Fond, Milwaukee
Delegate _____ Lars W. Kleppe, Beloit
Alternate _____ Robert A. Scheidt, Milwaukee

SECTION ON PEDIATRICS
Chairman _____ Stewart L. Griggs, Green Bay
Secretary _____ Edward Zupanc, Monroe
Delegate _____ Richard L. Myers, Green Bay
Alternate _____ J. R. Guy, Waukesha

SECTION ON PUBLIC HEALTH
President _____ Ruth Church, Waukesha
Secretary _____ Josef Preizler, Madison
Delegate _____ C. K. Kincaid, Madison
Alternate _____ G. M. Shinners, Green Bay

SECTION ON RADIOLOGY
President _____ Howard Mauthe, Fond du Lac
Secretary _____ Harold F. Ibach, Milwaukee
Delegate _____ Wayne M. Rounds, Madison
Alternate _____ Alan B. Fidler, Milwaukee

SECTION ON SURGERY
President _____ Irvin Schulz, Milwaukee
Secretary _____ John T. Mendenhall, Madison
Delegate _____ James M. Sullivan, Milwaukee
Alternate _____ B. Jack Longley, Madison

SECTION ON UROLOGY
President _____ Edward A. Stika, Racine
Secretary _____ John Wear, Jr., Madison
Delegate _____ John P. McCann, La Crosse
Alternate _____ Vacancy

PHYSICIANS EXEMPT FROM JURY DUTY

You don't have to serve as a juror unless you want to. All practicing physicians, surgeons, and dentists are exempt. This doesn't mean that you are disqualified from jury duty. The exemption is a personal privilege which you may claim or waive as you wish.

If you are called to act as a juryman and wish to take advantage of your exemption, appear in court when called and state the cause of your exemption to the presiding judge.

Reference: Section 255.02 (2), Wisconsin Statutes, 1965.

PRESIDENTS AND SECRETARIES, WISCONSIN SPECIALTY SOCIETIES

WISCONSIN ALLERGY SOCIETY
President—John A. Arkins, MD, (Oct. 1967), Milwaukee
Secretary—R. M. Heywood, MD, (Oct. 1967), Marshfield

WISCONSIN SOCIETY OF ANESTHESIOLOGISTS
President—Robert Bjurstrom, MD, (Oct. 1967), Eau Claire
Secretary—Ruth A. Stoerker, MD, (Oct. 1967), Madison

WISCONSIN DERMATOLOGICAL SOCIETY
President—G. O. Stubenrauch, MD, (Oct. 1967), Milwaukee
Secretary—Robert Pittelkow, MD, (Oct. 1967), Milwaukee

WISCONSIN ACADEMY OF GENERAL PRACTICE
President—C. A. Grand, MD, (Sept. 1967), Ashland
Secretary—Donald J. Heyrman, MD, (Sept. 1967), Menomonee Falls
Executive Secretary—Mr. Robert H. Herzog (Sept. 1967), Milwaukee

WISCONSIN SOCIETY OF INTERNAL MEDICINE
President—John H. Wishart, MD, (Sept. 1967), Eau Claire
Secretary—James W. Manier, MD, (Sept. 1967), Marshfield
Executive Secretary—Mr. Donald L. McNeil (Sept. 1967), Milwaukee

WISCONSIN SOCIETY OF OBSTETRICS AND GYNECOLOGY
President—Raymond Whitsitt, MD, (May 1967), Madison
Secretary—Richard C. Brown, MD, (May 1967), Eau Claire

WISCONSIN ORTHOPEDIC SOCIETY
President—Charles W. Christensen, MD, (Sept. 1968), Racine
Secretary—Marvin Nelson, MD, (Sept. 1968), Racine

Expiration date of term of office is indicated in parentheses.

WISCONSIN OTOLARYNGOLOGICAL SOCIETY
President—P. A. Sciarra, MD, (Sept. 1967), Sheboygan
Secretary—Maxine Bennett, MD, (Sept. 1969), Madison

WISCONSIN SOCIETY OF PATHOLOGISTS
President—P. G. Piper, MD, (Nov. 1967), Madison
Secretary—D. J. La Fond, MD, (Nov. 1967), Milwaukee

WISCONSIN ACADEMY OF PEDIATRICS
President—Stewart Griggs, MD, (Oct. 1967), Green Bay
Secretary—Edward Zupanc, MD, (Oct. 1967), Monroe

WISCONSIN SOCIETY OF PLASTIC SURGERY
President—Frank D. Bernard, MD, Madison
Secretary—Jack L. Teasley, MD, Milwaukee

WISCONSIN PSYCHIATRIC ASSOCIATION
President—B. Cullen Burris, MD, (May 1967), Milwaukee
Secretary—C. W. Osgood, MD, (May 1967), Wauwatosa

WISCONSIN ASSOCIATION OF PUBLIC HEALTH PHYSICIANS
President—Ruth E. Church, MD, (May 1967), Waukesha
Secretary—Josef Preizler, MD, (May 1967), Madison

WISCONSIN RADIOLOGICAL SOCIETY
President—Howard Mauthe, MD, (Sept. 1967), Fond du Lac
Secretary—Harold F. Ibach, MD, (Sept. 1967), Milwaukee

WISCONSIN SURGICAL SOCIETY
President—Russell P. Sinaiko, MD, (May 1967), Madison
Secretary-Treasurer—John Mendenhall, MD, (May 1968), Madison

WISCONSIN UROLOGICAL SOCIETY
President—Edward A. Stika, MD, (May 1967), Racine
Secretary—John B. Wear, Jr., MD, (May 1967), Madison

Find your future in the HEALTH FIELD

. . . a career guide

"Find your future in the health field," urges a brochure published by the Wisconsin Health Council, Inc. The brochure, developed with the assistance of the State Medical Society, contains information on 26 careers in health.

The publication is unique in its presentation. It is intended to supplement existing careers materials, and gives factual and statistical information on personal qualifications, educational requirements and opportunities, and employment possibilities in each of the fields. It places emphasis on Wisconsin.

Copies are distributed to guidance counselors in every Wisconsin school, and individual copies are available from the Wisconsin Health Council to youngsters interested in health careers.

Supplies are also available to physicians who participate in career days in their local schools; they may be obtained by writing the State Medical Society, Box 1109, Madison 53701.

The Wisconsin Health Council, which published the brochure, was formed in 1948 to stimulate citizen interest in public health in Wisconsin.

Past Presidents of the State Medical Society

Mason C. Darling, Fond du Lac 1841–1847
J. B. Dousman, Milwaukee 1848, 1849
A. L. Castleman, Delafield 1850, 1851
Harmon Van Dusen, Mineral Point 1852, 1853, 1854
A. L. Castleman, Delafield 1855
John Mitchell, Janesville 1856
D. Cooper Ayres, Green Bay 1857
Clark G. Pease, Janesville 1858, 1859
E. S. Carr, Madison 1860, 1861
Solomon Blood, Rochester 1862
(No meetings held from 1863 through 1866; apparently no new officers).
Harmon Van Dusen, Mineral Point 1867, 1868, 1869
Solon Marks, Milwaukee 1870
H. P. Strong, Beloit 1871
John Favill, Madison 1872
Harmon Van Dusen, Mineral Point 1873
M. Waterhouse, Portage 1874
J. T. Reeve, Appleton 1875
J. B. Whiting, Janesville 1876
J. K. Bartlett, Milwaukee 1877
Darius Mason, Prairie du Chien 1878
Nicholas Senn, Milwaukee 1879
J. G. Meachem, Sr., Racine 1880
Ira Manley, Jr., Markesan 1881
William Meacher, Portage 1882
T. P. Russell, Oshkosh 1883
N. M. Dodson, Berlin 1884
E. W. Bartlett, Milwaukee 1885
G. M. Steele, Oshkosh 1886
S. C. Johnson, Hudson 1887
L. G. Armstrong, Boscobel 1888
J. R. Barnett, Neenah 1889
E. M. Rogers, Hartford 1890
G. D. Ladd, Milwaukee 1891
G. F. Witter, Grand Rapids, Mich. 1892
B. T. Phillips, Menominee, Mich. 1893
B. C. Brett, Green Bay 1894
Almon Clarke, Sheboygan 1895
F. W. Epley, New Richmond 1896
B. O. Reynolds, Lake Geneva 1897
William Mackie, Milwaukee 1898
Herman Reineking, Milwaukee 1899
W. T. Sarles, Sparta 1900
J. F. Pritchard, Manitowoc 1901
W. H. Neilson, Milwaukee 1902
J. V. R. Lyman, Eau Claire 1903
F. E. Walbridge, Milwaukee 1904
C. W. Oviatt, Oshkosh 1905
J. R. Currens, Two Rivers 1906
L. H. Pelton, Waupaca 1907
W. E. Ground, Superior 1908
Gilbert E. Seaman, Madison 1909
Edward Evans, La Crosse 1910
Byron M. Caples, Waukesha 1911
John M. Dodd, Ashland 1912
Arthur J. Patek, Milwaukee 1913
Charles S. Sheldon, Madison 1914
T. J. Redelings, San Diego, Cal. 1915
L. J. Jermain, Milwaukee 1916
Hoyt E. Dearholt, Milwaukee 1917
Gustave Windesheim, Kenosha 1918
D. J. Hayes, Milwaukee 1919
C. R. Bardeen, Madison 1920
H. W. Abraham, Appleton* 1921
M. A. McGarty, La Crosse 1921
S. Hall, Ripon 1922
F. G. Connell, Oshkosh 1923
Rock Sleyster, Wauwatosa 1924
Wilson Cunningham, Platteville 1925
Joseph F. Smith, Wausau 1926
Arthur W. Rogers, Oconomowoc 1927
John J. McGovern, Milwaukee 1928
Karl W. Doege, Marshfield 1929
F. J. Gaenslen, Milwaukee 1930
A. J. McDowell, Soldiers Grove** 1931
C. A. Harper, Madison 1931
Otho Fiedler, Sheboygan 1932
Reginald H. Jackson, Madison 1933
Stanley J. Seeger, Texarkana, Texas 1934
T. J. O'Leary, Superior 1935
R. M. Carter, Green Bay 1936
Stephen E. Gavin, Fond du Lac 1937
James C. Sargent, Milwaukee 1938
A. E. Rector, Appleton 1939
R. G. Arveson, Frederic 1940
R. P. Sproule, Milwaukee 1941
Gunnar Gundersen, La Crosse 1942
F. E. Butler, Menomonie 1943
R. M. Kurten, Racine 1944
Charles Fidler, Milwaukee 1945
P. R. Minahan, Green Bay 1946
C. A. Dawson, River Falls 1947
W. D. Stovall, Madison 1948
K. H. Doege, Marshfield 1949
J. W. Truitt, Milwaukee 1950
H. H. Christofferson, Colby 1951
A. H. Heidner, West Bend 1952
J. C. Griffith, Milwaukee 1953
H. Kent Tenney, Madison 1954
Arthur J. McCarey, Green Bay*** 1955
Ervin L. Bernhart, Milwaukee 1956
L. O. Simenstad, Osceola 1957
Harry E. Kasten, Beloit 1958
Jerome W. Fons, Milwaukee**** 1958
W. B. Hildebrand, Menasha 1960
E. D. Sorenson, Elkhorn 1961
L. H. Lokvam, Kenosha 1962
N. A. Hill, Madison 1963
W. J. Egan, Milwaukee 1964
W. P. Curran, Antigo 1965
J. H. Houghton, Wisconsin Dells 1966

* Died during term of office as president-elect.

** Resigned, because of health, prior to taking office.

*** Through April, 1955. The date of the Society's Annual Meeting, at which the president is elected, was changed from October to May during this year.

**** Resigned during term of office.

Recipients of the Council Award

Established in 1929, the Council Award represents the highest award in the power of the State Medical Society to bestow upon one of its members or, at times, on one closely connected with the work of the profession in the state. It is granted only upon occasion. It is granted only by unanimous vote of the Council. It is granted only to such as have served with outstanding distinction the science of medicine, their fellow physicians, and the public.

Of those who have been its recipients, it may truly be said that they have personified the highest traditions of medicine in their devotion to the public good.

John M. Dodd, M.D.†	1930
Cornelius A. Harper, M.D.†	1930
John J. McGovern, M.D.†	1931
Louis M. Jermain, M.D.†	1931
Edward Evans, M.D.†	1931
Mina B. Glasier, M.D.†	1932
Arthur W. Rogers, M.D.†	1934
Rock Sleyster, M.D.†	1934
Olin West, M.D.†	1934
Edward A. Birge, Ph.D.†	1935
Arthur J. Patek, M.D.†	1935
Joseph F. Smith, M.D.†	1937
Eben J. Carey, M.D.†	1938
William S. Middleton, M.D.	1938
Fred G. Johnson, M.D.†	1939
William D. Stovall, M.D.	1940
Ludvig Hektoen, M.D.*†	1941
Stephen E. Gavin, M.D.†	1944
F. Gregory Connell, M.D.	1947
E. R. Schmidt, M.D.†	1949
Armand J. Quick, M.D.	1950
F. A. Stratton, M.D.†	1951
Gunnar Gundersen, M.D.	1953
W. J. Meek, Ph.D.†	1953
R. G. Arveson, M.D.†	1957
Edwin B. Fred, Ph.D.	1958
Harry Beckman, M.D.	1959
Elizabeth Comstock, M.D.	1961
Harry Steenbock, Ph.D.	1963
Francis J. L. Blasingame, M.D.	1964
C. N. Neupert. M.D.	1965
Spencer D. Beebe, M.D.	1965
Frank L. Weston, M.D.**	1966
Robert E. Fitzgerald, M.D.**	1966

* Centennial Award. † Deceased.
** 125th Anniversary Award.

Recipients of the Presidential Citation

The President of the State Medical Society, with the unanimous approval of the Council, has the privilege of presenting a Presidential Citation to a nonphysician who has made a significant contribution to medicine or public health.

Since the establishment of this citation in 1959, the following persons have been so recognized:

Reuben Knutson (Chairman, Wisconsin Industrial Commission)	1959
Helen Crawford (Librarian, University of Wisconsin Medical School Library)	1962
The Rev. Edward J. O'Donnell, S. J. (Chancellor of Marquette University)	1963
Harvey Higley (Former Administrator of Veterans Affairs), Marinette	1965
Francis J. Wilcox (National Board Chairman, American Cancer Society, and Board of Directors, Wisconsin Division, ACS), Eau Claire	1966

Statute Authorizes Gifts of Human Bodies or Parts

The general rule of law, in the absence of a statute to the contrary, is that the surviving spouse or next of kin controls the disposition of the body of a deceased person. At the suggestion of interested physicians the Wisconsin Legislature enacted a statute in 1961 which needs to be better known to those interested in arranging for the gift of human bodies or parts thereof to medical schools or medical banks for certain purposes.

The statute provides as follows:

155.06 Gifts of bodies or parts thereof. (1) Every person of the age of 21 years or older, of sound mind, may make a gift, during his lifetime, of all or any part of his body to any medical school or to any bank handling parts of the body, provided such gift is for scientific, medical or educational purposes. Such a body or parts thereof shall be made available to the medical school or bank after the death of the donor by the person having custody of the body.

(2) Such a gift shall be evidenced by a written instrument, signed by the donor and by 2 competent witnesses who know the signature to be that of the donor.

(3) The gift by any person of all or a portion of his body made pursuant to this statute may be revoked by the donor at any time during his lifetime.

(4) The donee may accept or reject the gift. If the donee accepts, he or his agent may cause to be removed from the body that portion given to the donee. If the entire body is given, it shall not be delivered to the donee or his agent until after the surviving spouse or other person who assumes custody of the body has had an opportunity to provide a funeral service or other last rites for the deceased.

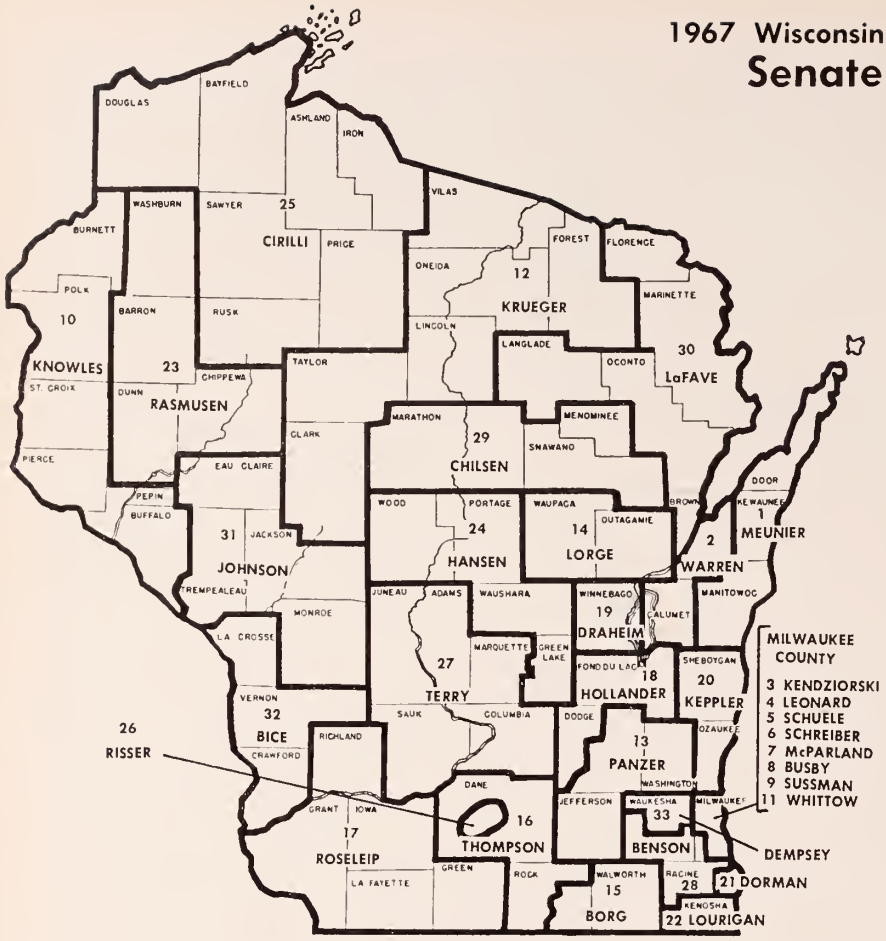
(5) No person, acting in good faith to carry out the written directions of the donor, shall be liable for damages in any civil suit for his actions notwithstanding the fact that, for any reason, the supposed gift is invalid.

The 1967 Wisconsin Legislature

DIRECTORY OF MEMBERS

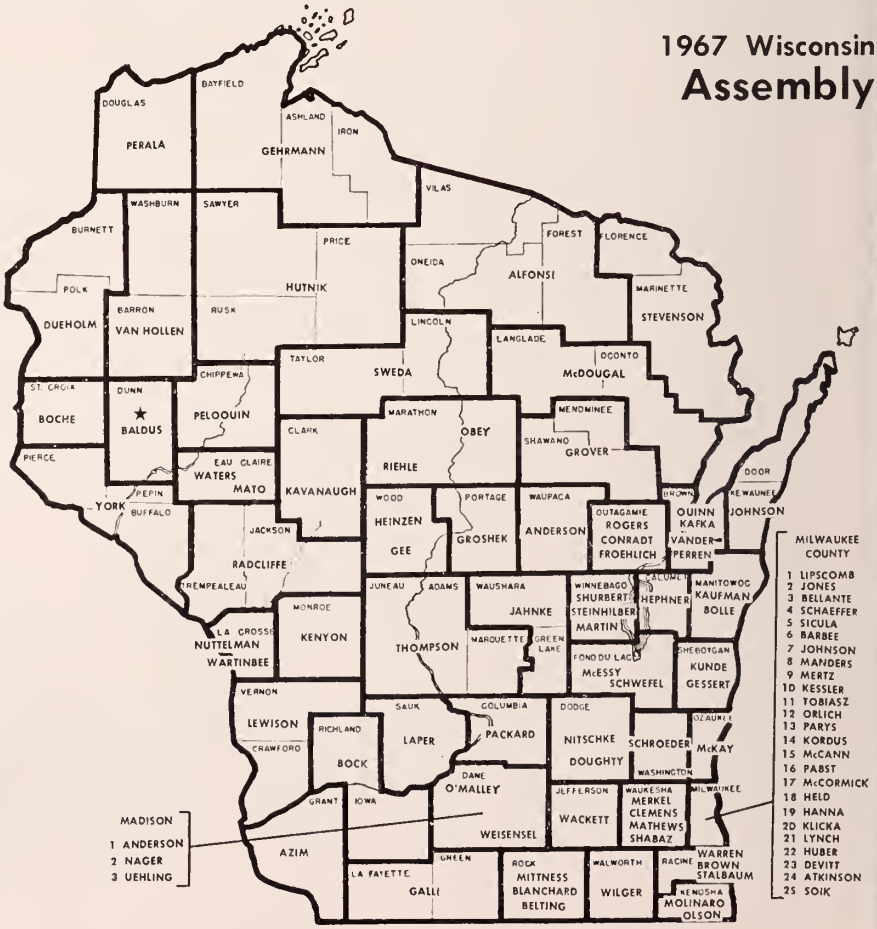
Prepared by the
Wisconsin Taxpayers Alliance
Madison, Wisconsin 53703

1967 Wisconsin Senate



Note: The senate districts shown on the map above are the districts created when the Wisconsin supreme court reapportioned legislative districts. The names of the senators elected in November 1966 from the odd-numbered districts are listed as are holdover senators whose term of office does not expire until 1969. A list of all of the senators serving in the 1967 senate and a description of the area included in their districts are found on page 87.

1967 Wisconsin Assembly



★Note: (Map at right) Election in Dunn County Contested. See Page 88.

State Officers

Governor—KNOWLES, WARREN P. (R), 251 W. 2nd St., New Richmond

Lt. Governor—OLSON, JACK B. (R), 925 Church St., Wisconsin Dells

Secy. of State—ZIMMERMAN, ROBERT C. (R), 2810 Arbor Drive, Madison

State Treasurer—SMITH, DENA A. (R), 1628 W. Wisconsin Ave., Milwaukee

Attorney General—LAFOLLETTE, BRONSON C. (D), 733 Lakewood Blvd., Madison

Members of Congress from Wisconsin

SENATORS

Senate Office Bldg., Washington, D.C.

PROXMIRE, WILLIAM (D), 4613 Buckeye Rd., Madison

NELSON, GAYLORD (D), 5750 Bittersweet Pl., Madison

REPRESENTATIVES

House Office Bldg., Washington, D.C.

Dist.

1. SCHADEBERG, HENRY C. (R), 333 Emerson St., Burlington
2. KASTENMEIER, ROBERT W. (D), 300 N. Water St., Watertown
3. THOMSON, VERNON W. (R), 578 E. Second St., Richland Center
4. ZABLOCKI, CLEMENT J. (D), 3245 W. Drury Lane, Milwaukee
5. REUSS, HENRY S. (D), 925 E. Wells St., Milwaukee
6. STEIGER, WILLIAM A. (R), 684 Oak St., Oshkosh
7. LAIRD, MELVIN R. (R), 313 E. Third St., Marshfield
8. BYRNES, JOHN W. (R), 406 N. Washington St., Green Bay
9. DAVIS, GLENN R. (R), 2300 Springdale Rd., New Berlin
10. O'KONSKI, ALVIN E. (R), Mercer

Members of the 1967 Wisconsin Senate

Dist.	Name (Party)	District (Counties)	Address
1.	*Meunier, Alex J. (R)	Door, Kewaunee, Manitowoc	Route 1, Sturgeon Bay
2.	–Warren, Robert W. (R)	1st, 2nd assembly districts, Brown; Calumet	200 W. Briar Lane, Green Bay
3.	*Kendziorski, Casimir (D)	11th, 12th, 14th assembly districts, Milwaukee	2025 S. 14th St., Milwaukee
4.	–Leonard, Jerris (R)	3rd, 18th, 25th assembly districts, Milwaukee	9420 N. Sleepy Hollow Lane, Milwaukee
5.	*Schuele, Wilfred (D)	2nd, 9th, 15th assembly districts, Milwaukee	3036 N. 84th St., Milwaukee
6.	–Schreiber, Martin J., Jr. (D)	1st, 5th, 7th assembly districts, Milwaukee	3128 N. 50th St., Milwaukee
7.	*McParland, Leland S. (D)	17th, 19th, 24th assembly districts, Milwaukee	4757 S. Packard Ave., Cudahy
8.	–Busby, Allen J. (R)	20th, 21st, 22nd assembly districts, Milwaukee	1673 S. 53rd St., Milwaukee
9.	*Sussman, Norman (D)	4th, 6th, 13th assembly districts, Milwaukee	1396 W. Fond du Lac Ave., Milwaukee
10.	–Knowles, Robert P. (R)	Buffalo, Pepin, Pierce, Burnett, Polk, St. Croix	New Richmond
11.	Whittow, Wayne F. (D)	8th, 10th, 16th assembly districts, Milwaukee	4921 W. Washington Blvd., Milwaukee
12.	–Krueger, Clifford W. (R)	Clark, Forest, Oneida, Vilas, Lincoln, Taylor	122 N. State St., Merrill
13.	*Panzer, Frank E. (R)	1st assembly district, Dodge; Jefferson, Washington	Route 1, Brownsville
14.	–Lorge, Gerald D. (R)	Outagamie, Waupaca	Bear Creek
15.	Borg, George M. (R)	1st, 3rd assembly districts, Rock; Walworth	Rt. 2, Box 454, Delavan
16.	–Thompson, Carl W. (D)	4th, 5th assembly districts, Dane; 2nd assembly district, Rock	Route 3, Stoughton
17.	*Roseleip, Gordon W. (R)	Grant, Green, Iowa, Lafayette, Richland	Box 167, Darlington
18.	–Hollander, Walter G. (R)	2nd assembly district, Dodge; Fond du Lac	Route 1, Rosendale
19.	*Draheim, William A. (R)	Winnebago	913 Hewitt St., Neenah
20.	–Keppler, Ernest C. (R)	Ozaukee, Sheboygan	909 New York Ave., Sheboygan
21.	*Dorman, Henry (D)	1st, 2nd assembly districts, Racine	422 16th St., Racine
22.	–Lourigan, Joseph (D)	Kenosha	3604 19th Ave., Kenosha
23.	*Rasmusen, Holger B. (R)	Barron, Chippewa, Dunn, Washburn	722 Franklin St., Spooner
24.	–Hansen, William C. (D)	Green Lake, Waushara, Portage, Wood	Route 4, Stevens Point
25.	Cirilli, Arthur A. (R)	Ashland, Bayfield, Douglas, Iron, Price, Rusk, Sawyer	909 E. 4th St., Superior
26.	–Risser, Fred A. (D)	1st, 2nd, 3rd assembly districts, Dane	5409 Esther Beach Rd., Madison
27.	Terry, Walter E. (R)	Adams, Columbia, Juneau, Marquette, Sauk	Route 3, Baraboo
28.	–Benson, Taylor (D)	23rd assembly district, Milwaukee; 3rd assembly district, Racine; 4th assembly district, Waukesha	6729 Hwy. 38, Franksville
29.	Chilsen, Walter John (R)	Marathon, Menominee, Shawano	Rt. 5, Box 25, Wausau
30.	–LaFave, Reuben (R)	3rd assembly district, Brown; Florence, Marinette, Langlade, Oconto	Route 1, Oconto
31.	Johnson, Raymond C. (R)	Eau Claire, Jackson, Monroe, Trempealeau	221 N. 12th St., Eau Claire
32.	–Bice, Raymond C. (R)	Crawford, Vernon, La Crosse	2406 State St., La Crosse
33.	*Dempsey, Chester E. (R)	1st, 2nd, 3rd assembly districts, Waukesha	Route 1, Hartland

–Hold-over senator from 1965 legislature.

*Served in 1965 senate.

Senate terms for even-numbered districts expire on the second Wednesday of January 1969 and odd-numbered districts on the second Wednesday of January 1971.

Members of the 1967 Wisconsin Assembly

District (Counties)	Name (Party)	Address
Adams, Juneau and Marquette	Thompson, Tommy G. (R)	1407 Academy St., Elroy
Ashland, Bayfield and Iron	•Gehrmann, Bernard E. (R)	801 Prentice Ave., Ashland
Barron and Washburn	Van Hollen, John C. (R)	720 Lakeview Dr., Chetek
Bayfield (See Ashland)		
Brown, 1st	•Quinn, Jerome (R)	137 N. Oakland Ave., Green Bay
Brown, 2nd	•Kafka, Lawrence J. (R)	Route 3, Denmark
Brown, 3rd	•Vanderperren, Cletus (D)	Route 5, Green Bay
Buffalo, Pepin and Pierce	York, Stanley (R)	118 N. Third St., River Falls
Burnett and Polk	•Dueholm, Harvey L. (D)	Luck
Calumet	Hephner, Gervase A. (D)	Rte. 1, Box 15, Chilton
Chippewa	•Peloquin, Bruce S. (D)	497 Irvine St., Chippewa Falls
Clark	Kavanaugh, William C. (R)	Miller St., Greenwood
Columbia	Packard, Wesley L. (R)	143 S. Main St., Lodi
Crawford and Vernon	•Lewison, Bernard (R)	11 S. Washington Heights, Viroqua
Dane, 1st	•Anderson, Norman C. (D)	5325 Marsh Rd., Madison
Dane, 2nd	•Nager, Edward (D)	840 Spaight St., Madison
Dane, 3rd	•Uehling, Robert O. (R)	4330 Keating Terrace, Madison
Dane, 4th	Weisensel, Russel R. (R)	Twin Lane Rd., Sun Prairie
Dane, 5th	•O'Malley, David D. (D)	315 W. Main St., Waunakee
Dodge, 1st	•Doughty, Esther S. (R)	211 N. Hubbard St., Horicon
Dodge, 2nd	•Nitschke, Elmer C. (R)	208 Hamilton St., Beaver Dam
Door and Kewaunee	•Johnson, Lawrence H. (R)	Route 2, Algoma
Douglas	•Perala, Reino A. (D)	824 N. 22nd St., Superior
Dunn	Baldus, Alvin (D)	1901 S. Broadway, Menomonie
Eau Claire, 1st	Waters, Wilmer R. (R)	1417 Birney St., Eau Claire
Eau Claire, 2nd	•Mato, Louis V. (D)	Fairchild
Florence and Marinette	•Stevenson, Leslie R. (D)	603 Ogden St., Marinette
Fond du Lac, 1st	•McEssy, Earl F. (R)	361 Forest Ave., Fond du Lac
Fond du Lac, 2nd	•Schwefel, William S. (R)	Route 1, Oakfield
Forest, Oneida and Vilas	•Alfonsi, Paul R. (R)	Minocqua
Grant	•Azim, James N., Jr. (R)	Muscoda
Green and Lafayette	•Galli, G. Fred (R)	804 27th Ave., Monroe
Green Lake and Waushara	•Jahnke, Franklin M. (R)	Route 3, Markesan
Iowa and Richland	•Bock, Gregor J. (R)	Highland
Iron (See Ashland)		
Jackson and Trempealeau	•Radcliffe, John (D)	Strum
Jefferson	•Wackett, Byron F. (R)	100 Oak Hill Ct., Watertown
Juneau (See Adams)		
Kenosha, 1st	•Molinaro, George (D)	424 44th St., Kenosha
Kenosha, 2nd	Olson, Russell (R)	Bassett
Kewaunee (See Door)		
La Crosse, 1st	•Wartinbee, D. Russell (R)	1444 Wood St., La Crosse
La Crosse, 2nd	•Nuttelman, Norbert (R)	Route 1, West Salem
Lafayette (See Green)		
Langlade and Oconto	•McDougal, Milton (D)	402 Chestnut Ave., Oconto Falls
Lincoln and Taylor	•Sweda, Joseph (D)	Luhlin
Manitowoc, 1st	•Kaufman, Eugene S. (D)	918 S. 13th St., Manitowoc
Manitowoc, 2nd	•Bolle, Everett E. (D)	Francis Creek
Marathon, 1st	•Riehle, Ben A. (D)	Route 3, Athens
Marathon, 2nd	•Obey, David R. (D)	515 N. 9th Ave., Wausau
Marinette (See Florence)		
Marquette (See Adams)		
Menominee and Shawano	•Grover, Herbert J. (D)	Route 3, Shawano
Milwaukee, 1st	•Lipscomb, Mark G., Jr. (D)	2120 W. Colfax Pl., Milwaukee
Milwaukee, 2nd	•Jones, Joseph E. (D)	4285 N. 26th St., Milwaukee
Milwaukee, 3rd	Bellante, Joseph F., Jr. (R)	1035 E. Brady St., Milwaukee
Milwaukee, 4th	•Schaeffer, Frank E., Jr. (D)	1623 W. Wisconsin Ave., Milwaukee
Milwaukee, 5th	Sicula, Paul E. (D)	3287 N. 48th St., Milwaukee
Milwaukee, 6th	•Barbee, Lloyd A. (D)	321 E. Meinecke St., Milwaukee
Milwaukee, 7th	•Johnson, William A. (D)	3403 N. 22nd St., Milwaukee
Milwaukee, 8th	•Manders, Adrian J. (D)	1406 S. 36th St., Milwaukee
Milwaukee, 9th	•Mertz, Edward F. (D)	3112 W. Silver Spn Dr., Milwaukee
Milwaukee, 10th	•Kessler, Frederick P. (D)	3004 W. Wells St., Milwaukee
Milwaukee, 11th	•Tobiasz, Raymond J. (D)	3145 S. 50th St., Milwaukee
Milwaukee, 12th	Orlich, Sam L. (D)	1307 S. 11th St., Milwaukee
Milwaukee, 13th	•Parys, Ronald G. (D)	1221 E. Clarke St., Milwaukee
Milwaukee, 14th	•Kordus, Robert P. (D)	3457 S. 25th St., Milwaukee
Milwaukee, 15th	•McCann, James A. (D)	3537 N. 95th St., Milwaukee
Milwaukee, 16th	Pahst, Richard E. (D)	457A S. 74th St., Milwaukee
Milwaukee, 17th	•McCormick, John E. (D)	2954 S. Wentworth Ave., Mlwaukee
Milwaukee, 18th	Held, James E. (R)	8723 W. Mill Rd., Milwaukee
Milwaukee, 19th	•Hanna, Daniel D. (D)	639 W. Layton Ave., Milwaukee
Milwaukee, 20th	Klicka, George H. (R)	2115 N. 86th St., Wauwatosa
Milwaukee, 21st	•Lynch, Richard J. (D)	824 S. 120th St., W Allis
Milwaukee, 22nd	•Huber, Robert T. (D)	2228 S. 78th St., W Allis
Milwaukee, 23rd	Devitt, James C. (R)	5151 Root River Pkw Greenfield
Milwaukee, 24th	•Atkinson, William P. (D)	1115 16th Ave., Sout Milwaukee
Milwaukee, 25th	•Soik, Nile W. (R)	6266 N. Santa Mon Blvd., Whitefish B
Monroe	•Kenyon, Kyle (R)	Route 4, Tomah
Oconto (See Langlade)		
Oneida (See Forest)		
Outagamie, 1st	•Froehlich, Harold V. (R)	421 W. 6th St., Appleton
Outagamie, 2nd	•Rogers, William J. (D)	1317 Hillcrest Dr., Kaukauna
Outagamie, 3rd	•Conradt, Ervin W. (R)	Route 2, Shiocton
Ozaukee	•McKay, J. Curtis (R)	Route 1, Box 371, Cedarburg
Pepin (See Buffalo)		
Pierce (See Buffalo)		
Polk (See Burnett)		
Portage	Groshek, Leonard (D)	Route 1, Stevens Pob
Price, Rusk and Sawyer	•Hutnik, Willis J. (R)	716 E. Third St., N., Ladysmith
Racine, 1st	•Warren, Earl W. (D)	2809 Virginia St., Racine
Racine, 2nd	•Brown, Manny S. (D)	2817 Ruby Ave., Racl
Racine, 3rd	•Stalhaum, Merrill E. (R)	Route 1, Box 38, Waterford
Richland (See Iowa)		
Rock, 1st	•Mittness, Lewis T. (D)	730 N. Ringold St., Janesville
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Rusk (See Price)		
St. Croix	Boche, Robert M. (R)	R.R., Star Prairie
Sauk	Laper, Oscar (R)	Rock Springs
Sawyer (See Price)		
Shawano (See Menominee)		
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Taylor (See Lincoln)		
Trempealeau (See Jackson)		
Vernon (See Crawford)		
Vilas (See Forest)		
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Washburn (See Barron)		
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(Continued on next page)

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No. 3—485 South Military Road; Phone 922–1290 ---------- Fond du Lac
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OASI DISABILITY DETERMINATION SECTION, 137 East Wilson St., Madison 53702, Telephone 266–1565

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"March of Medicine" is in its 21st consecutive year of radio broadcasting. The programs, which are tape recorded, feature H. Kent Tenney, M.D., discussing various health problems with a lay person who is called "Your Medical Reporter." At present 52 stations in Wisconsin are cooperating in presenting this program as a public service feature. The most recent schedule is as follows:

Station	*City*	*Day*	*Time*
WATK	Antigo	Saturday	8:45 a.m.
WHBY	Appleton	Wednesday	7:05 p.m.
WATW	Ashland	Saturday	11:15 a.m.
*WLBL	Auburndale	Wednesday	9:15 a.m.
WWIS	Black River Falls	Saturday	10:45 a.m.
*WHSA	Brule	Wednesday	9:15 a.m.
*WHKW	Chilton	Wednesday	9:15 a.m.
WAXX	Chippewa Falls	Sunday	10:00 a.m.
*WHWC	Colfax	Wednesday	9:15 a.m.
*WHAD	Delafield	Wednesday	9:15 a.m.
WERL	Eagle River	Saturday	9:45 a.m.
WBIZ	Eau Claire	Sunday	6:45 p.m.
KFIZ	Fond du Lac	Sunday	10:15 a.m.
WJPG	Green Bay	Saturday	8:45 a.m.
WHSM	Hayward	Saturday	9:45 a.m.
*WHHI	Highland	Wednesday	9:15 a.m.
*WHLA	Holmen	Friday	10:30 a.m.
WKAU	Kaukauna	Saturday	9:45 a.m.
WLIP	Kenosha	Saturday	9:10 a.m.
WLDY	Ladysmith	Saturday	9:00 a.m.
WMHR	Lake Geneva	Sunday	8:45 a.m.
WHA	Madison	Wednesday	9:15 a.m.
*WHA-AM	Madison	Wednesday	9:00 a.m.
*WHA-FM	Madison	Wednesday	9:00 a.m.
WIBA	Madison	Saturday	11:15 a.m.
WOMT	Manitowoc	Saturday	9:15 a.m.
WMAM	Marinette	Sunday	10:30 p.m.
WIGM	Medford	Saturday	9:45 a.m.
WMNE	Menomonie	Thursday	10:45 a.m.
WXMT	Merrill	Saturday	9:45 a.m.
WEKZ	Monroe	Saturday	1:45 p.m.
WNAM	Neenah	Sunday	7:05 p.m.
WCCN	Neillsville	Saturday	9:00 a.m.
WPFP	Park Falls	Saturday	10:45 a.m.
WSWW	Platteville	Saturday	11:15 a.m.
WPDR	Portage	Thursday	10:45 a.m.
WIBU	Poynette	Thursday	2:35 p.m.
WPRE	Prairie du Chien	Saturday	9:45 a.m.
WRJN	Racine	Sunday	6:30 p.m.
WRDB	Reedsburg	Saturday	12:45 p.m.
WOBT	Rhinelander	Saturday	10:15 a.m.
WJMC	Rice Lake	Saturday	9:45 a.m.
WCWC	Ripon	Saturday	10:45 a.m.
WVLR	Sauk City	Sunday	10:15 a.m.
WTCH	Shawano	Saturday	6:15 p.m.
WDOR	Sturgeon Bay	Tuesday	9:05 a.m.
WTRW	Two Rivers	Wednesday	11:00 a.m.
WISV	Viroqua	Saturday	8:45 a.m.
WTTN	Watertown	Friday	11:30 a.m.
*WHRM	Wausau	Friday	10:30 a.m.
WSAU	Wausau	Saturday	5:15 p.m.
WBKV	West Bend	Saturday	11:15 a.m.

*Radio stations in the state network.

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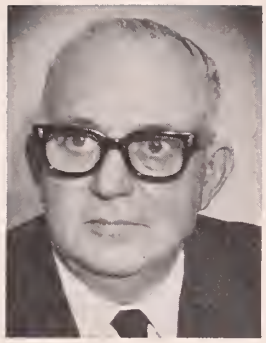

FRANK E. DREW, M.D.
Milwaukee

Turn Over a New Leaf

■ START THE NEW YEAR RIGHT! We all have the best intentions for handling our records, correspondence, and forms in a prompt and efficient manner. The best of these good thoughts are soon lost in our busy life, and soon these chores pile up and become a burden.

This past year has seen our load in records and forms increase many-fold because of the advent of Medicare. We may not like the prospects of being a glorified secretary or clerk, when our training was to be a physician; but we have no choice in this modern, complex world of complicated business and the age of computers. We are victims of the side issue of medical business; and forms and reports are now part of our daily life, and will remain so for ad infinitum!

One legitimate complaint in this form process has come to our attention. The Veterans Administration has been very cooperative in furnishing fee-basis physicians a record copy of all examinations and procedures which are done in the veterans outpatient clinic when the patient appears there for an examination.

When the examination and procedures are done by the fee-basis physician in his office or affiliated hospital, these reports should be sent promptly to the Veterans Administration for its appraisal and records. This is not only essential but also fair to both the veteran patient and the Veterans Administration. This compliance is necessary to determine whether the veteran is keeping up with the needed treatment and that he is being given adequate care. This simple requirement is necessary to save the veteran being called into the veteran facility for evaluation of his current status.

Some of the periodic, mandatory examinations possibly could be eliminated if the Veterans Administration had sufficient information that the veteran is being adequately cared for and that his condition is under control. Many tests are being performed by fee-basis physicians prior to any request for their authorization. The tests are performed and billed to the Veterans Administration without supporting reports, results, or information. It is difficult to understand that these services are expected to be paid for and no information is available. Forms are available to report charges and results and in all due fairness should be used, and maybe reported quarterly or semi-annually.

There would be great consternation and protest if the Veterans Administration were to abolish treatment by the private fee-basis physician. This could result in the failure on the part of physicians to furnish reports of these veteran patients to the proper authorities. This paper work may be troublesome and annoying but let us make every effort this New Year to comply with a just request. Your medical society would have no just grounds to defend your negligence if you continue not to comply with a fair request for both the veteran patient and the Veterans Administration. This is a two-way street!

F. E. Drew M.D.

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EDITORIALS

D. N. GOLDSTEIN, M. D., *Editorial Director*

Name That Drug

■ AFTER EXTENSIVE STUDY, the American Medical Association's Council on Drugs has recommended that physicians request medications dispensed to their patients be marked with the identity of the drug and its strength. This appears to be a progressive step consonant with the changed conditions of modern medical practice. Recently the Council of the State Medical Society of Wisconsin considered all aspects of the problem and decided that such decisions were properly left to the judgment of the individual physician.

Until recent decades the general public's lack of knowledge or misinformation about medical matters discouraged the doctor from an open discussion of the details of treatment with a patient. Usually, awesome sounding pharmaceutical names meant nothing to the patient, and, given the relative stability of most sections of the population, had little value to the patient as a means of identification. The expression "the little pink pills" communicated much more than the polysyllabic name of the drug.

Nowadays, however, patients are considerably more sophisticated about medical matters. Popular magazines, newspapers, radio, and television have made the names of frequently used drugs commonplace, and many women have derived a rudimentary medical education from the pages of the homemaker journals. But more important, patients move about more today than they have ever done. The possibility of changing doctors from locality to locality dictates that the patient have more information about his treatment available to him. Further, more prescription drugs are used today than ever before, and the "little pink pills" description is no longer adequate as an identification.

Most pharmacists resist this change in practice, offering reasons that, in the opinion of the AMA's Council on Drugs, are less valid than those in favor of labeling. To satisfy the scruples of the pharmacist with regard to labeling, it is necessary only for the doctor to indicate on his prescription that he wishes the container appropriately labeled. The AMA Council suggests that the doctor have two prescription pads, one imprinted with the direction to label, and the other to be used in the few instances where labeling may not be in the patient's interest. Thus, the druggist is released from responsibility of labeling, and the decision to do so rests with the physician.

It is to be hoped that all doctors follow the recommendations of the Council on Drugs with regard to labeling prescriptions. It represents movement toward a mature relationship with the patient, in which the doctor returns some of the confidence he asks the patient to repose in him. Best of all, it assures a means of instant, positive identification in emergency situations.—D.N.G.

Guest Editorial

Trauma Mortality Study

PHYSICIANS AND professional societies of physicians are no more competent to evaluate highway engineering, seat belts, or implied consent laws than any other group of intelligent, well informed laymen. There is one area where our specialized expert knowledge could be helpful and is not being fully utilized. I refer to the management and care of serious accident victims who do not die from their injuries in the first day or two.

Writing concerned with medical care of accident victims emphasizes promptness in emergency room care and 24-hour emergency room coverage by a physician. These are desirable but may be of less importance than the planning of priority in treatment and continued aggressive therapy in the days and weeks after the patient leaves the emergency room.

The Motor Vehicle Department doesn't know (and would appreciate our help in finding out) how many deaths occur after hospitalization as distinguished from those that occur at the scene of the accident or the first few hours following the injury. Surely, if every death that occurs later than the first day or two following an accident were studied as carefully as our maternal deaths, we would learn a lot about trauma and its management that is not now generally known.

Perhaps a group of physicians qualified by training, interest, and demonstrated competence could be available in every urban center of the state for consultations and help in trauma management. To the objection that these men are already available, I can only say that the publicity and interest of the State Medical Society would make their advice and help more readily available and more eagerly sought. The subtle influence of the State Medical Society can have a real effect on the day to day practice of medicine. The organization of such a program in Wisconsin would save some lives now being lost—it is an appropriate concern of our State Medical Society.

—J. A. KILLINS, M.D., Green Bay

Dreggy Criticism

A RECENT ISSUE of *Medical World News,* an otherwise responsible publication sent no-charge to physicians everywhere, took a senseless swipe at state medical journals. In an article on specialization it reported that un-named "doctor-critics" said that the best scientific articles were first sent to national or regional journals and "only the dregs are submitted to state editors."

It would be interesting to have the statement documented, both as to source as well as identity of the so-called doctor-critics. It would also be interesting to learn what the writer of the article calls "the dregs."

Admittedly state medical journals lack the production gloss of the large national or regional journals; advertising revenues are usually less, their circulation base is usually smaller, and the money with which they work is frequently substantially less. This does not mean, however, that the quality of the research reported in state journals suffers by comparison with that offered in the better-heeled magazines.

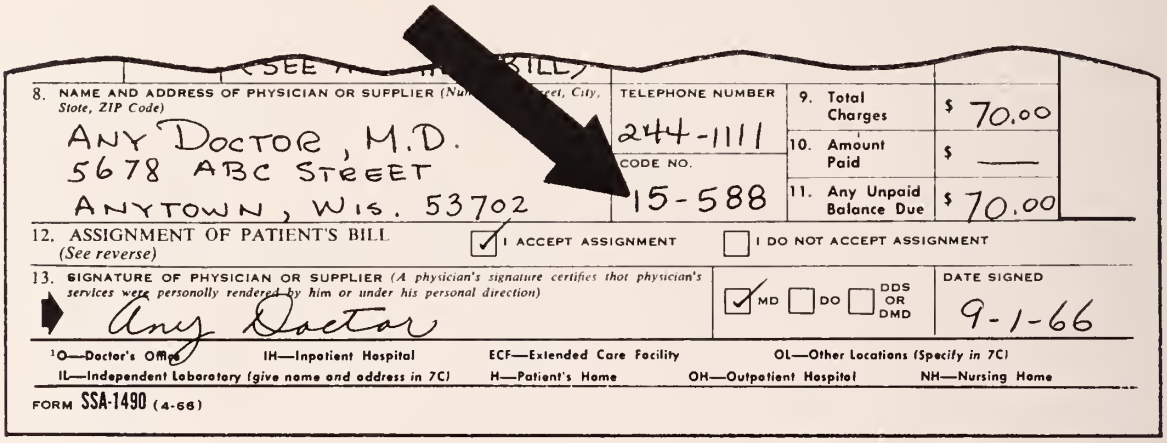
A quick check of the scientific articles appearing in the *Wisconsin Medical Journal,* for example, will give the lie to the *Medical World News* writer. Many fine, original articles are submitted and many articles are papers that were originally presented at an official meeting of the State Medical Society. A hard working editorial board selects the best of these for publication. And what is true in Wisconsin is generally true in most states. For state medical journals are an expression of the vitality of American medicine and proof that scientists are salted throughout the land, not merely in the large metropolitan centers. —D.N.G.

* * *

IT IS IMPORTANT that hospital staffs be vaccinated against smallpox, says the State Board of Health, since unrecognized cases of smallpox may be admitted to hospitals. Hospital personnel have a greater chance to be exposed to the disease.

The County-Doctor Code Number

Each physician has been assigned a separate five-digit code number which is used by WPS to speed claim processing and payments. On Medicare Part B claims that are sent directly to WPS (the assignment method of payment) the County-Doctor number should appear on the SSA-1490 form as shown in the following example:



8. NAME AND ADDRESS OF PHYSICIAN OR SUPPLIER (Number, Street, City, State, ZIP Code)
ANY DOCTOR, M.D.
5678 ABC STREET
ANYTOWN, WIS. 53702

TELEPHONE NUMBER: 244-1111
CODE NO.: 15-588

9. Total Charges: $ 70.00
10. Amount Paid: $ ——
11. Any Unpaid Balance Due: $ 70.00

12. ASSIGNMENT OF PATIENT'S BILL (See reverse) — [✓] I ACCEPT ASSIGNMENT [ ] I DO NOT ACCEPT ASSIGNMENT

13. SIGNATURE OF PHYSICIAN OR SUPPLIER (A physician's signature certifies that physician's services were personally rendered by him or under his personal direction): Any Doctor — [✓] MD [ ] DO [ ] DDS OR DMD — DATE SIGNED 9-1-66

[1]O—Doctor's Office; IH—Inpatient Hospital; ECF—Extended Care Facility; OL—Other Locations (Specify in 7C); IL—Independent Laboratory (give name and address in 7C); H—Patient's Home; OH—Outpatient Hospital; NH—Nursing Home

FORM SSA-1490 (4-66)

This same number is used to forward physician claim payments under all WPS-administered programs. If an inaccurate number appears the WPS computer will print an incorrect payment check, thus causing delay.

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Diagnosis and Treatment of Acute Pulmonary Embolism

By RICHARD D. SAUTTER, M.D. and DEAN A. EMANUEL, M.D.
Marshfield, Wisconsin

■ RECENTLY INTEREST in the diagnosis and treatment of pulmonary embolism has increased. It has been commonly stated that pulmonary embolism is the most common pulmonary complication in the hospitalized patient, and it claims some 47,000[1] lives per year. There are at hand several medical and surgical means of adequately treating this disease and reducing this toll.

At this clinic we have been intensely interested in this disease for the past four years. During this time we performed approximately 100 pulmonary arteriograms, 40 inferior caval ligations and 14 pulmonary embolectomies. However, at postmortem examination we still have found an 18% incidence of pulmonary embolism which was neither suspected nor diagnosed prior to death. Most important in the antemortem diagnosis of this disease is a high index of suspicion by the patient's attending physician.

At our institution, whenever the diagnosis of pulmonary embolism is suspected by the attending physician, a pulmonary arteriogram is performed. In addition to giving a positive diagnosis this provides an anatomical diagnosis as well. These studies yield valuable information which aids in the selection of the proper mode of therapy. A small unilateral embolus is adequately managed by anticoagulants. Vena caval ligation is mandatory in the patient who sustains a large or bilateral emboli. Pulmonary embolectomy is indicated in the patient who sustains a massive pulmonary embolus and is hypotensive.[2] Hypotension is a manifestation of decreased cardiac output due in large part to mechanical blockade of the pulmonary artery. Vasospasm in most instances plays a minor role. The patient who is not hypotensive is treated with inferior vena caval ligation. The heart–lung machine and operating suite are assembled prior to this procedure, for if the patient deteriorates or becomes hypotensive, embolectomy is performed.

Inferior vena caval ligation is preferred over the construction or placement of filter devices because it provides more positive assurance against further embolization. The filter operations do not stop small pulmonary emboli from reaching the lung. We have not had difficulty with stasis ulcers in those patients who did not have preexisting venous disease. It is very important that the ovarian veins or spermatic veins be ligated if there is any suggestion of inflammatory or thrombotic disease in areas drained by these veins.[3] Caval ligation is performed through a right flank incision, except in those instances when exploration of the spermatic or ovarian veins is necessary. All patients are treated with anticoagulants for a period of four to eight weeks. This prevents thrombosis beneath the caval ligature until adequate collaterals develop so that edema is not a disabling complication.

Our indication for pulmonary embolectomy is based primarily on the observation that in most instances acute pulmonary emboli spontaneously resolve. We have documented this fact in eight cases; the earliest

From the Marshfield Clinic and the Marshfield Clinic Foundation for Medical Research and Education.

spontaneous resolution occurred in 11 days and the latest in 128 days.[4] Fred et al have also reported this phenomena.[5] Pulmonary embolectomy for the preservation of pulmonary function is not indicated.

Because myocardial infarction is eight times as common as pulmonary embolism, the diagnosis should be confirmed prior to pulmonary embolectomy by arteriography. Diagnostic films may be obtained by placing a cardiac catheter in the pulmonary artery and power injecting the contrast media. Patients who are not near death or who have not suffered a cardiac arrest are studied in the Department of Radiology using a Sanchez rapid cassette changer. Patients who have suffered a cardiac arrest in the ward or are near death are taken to the operating room, placed on partial bypass, and with portable x-ray equipment, one to three films are obtained. By measurement of the pressure at the tip of the catheter, it is possible to insert the cardiac catheter in the pulmonary artery without the use of fluoroscopy. We have used this procedure in four instances and in two cases ruled out pulmonary embolism. While the films are not as of great detail as those obtained with the rapid cassette changer, it is possible to obtain diagnostic films.

Fourteen pulmonary embolectomies have been performed at this institution, only three of which were done without the use of cardiopulmonary bypass. In two of these instances, the cause of death was directly related to residual emboli. Cardiopulmonary bypass allows sufficient time for a deliberate attack on the obstructing material and offers the patient a greater chance for survival. It is also of some importance to note that in only one instance in these 14 cases were the emboli free-floating and easy to remove. In all other cases the emboli were adherent and difficult to remove from the pulmonary artery.

Cardiac arrest frequently accompanies pulmonary embolism and frequently occurs just after opening the pericardium. Partial cardiopulmonary bypass provides very good temporary support and should always be established prior to thoracotomy.

Peripheral venous cannulization can be carried out through the femoral or internal jugular vein.[6] Internal jugular vein cannulization is preferred because total bypass can be then established with a single catheter. It also allows the establishment of partial bypass somewhat more rapidly by allowing two surgical teams to operate in two separate areas. This technique has been used in eight instances, and in each case has always provided completely adequate flow and complete decompression of the superior vena cava. The right internal jugular vein is isolated through a small neck incision and tied distally. A large catheter, usually a No. 38 to 40 French is selected and four holes cut in the sides of the catheter, 15 cm from its tip. The jugular vein is then encircled with an umbilical tape to serve as a tourniquet and this catheter inserted down to and through the right atrium. It can be inserted into the inferior vena cava so that after opening the thorax, tourniquets about the superior and inferior vena cava may be placed and total decompression of the right side of the heart accomplished. The use of the femoral vein is more convenient when the patient is awake for it can be isolated under local anesthesia. It does, however, require that a second catheter be placed in the heart after thoracotomy, and it is inconvenient to use this catheter for venous return after the inferior cava is tied.

Our surgical technique for pulmonary embolectomy has been standardized in the last several procedures. Partial bypass, where only a portion of the venous return is directed into the heart-lung machine, is always established prior to thoracotomy. This allows both the heart and the heart-lung machine to perfuse the body. The chest is then opened through a sternal splitting incision which provides excellent exposure. Even in a patient treated with heparin, the bleeding from this incision is not excessive because of the decrease in the cardiac output. After the establishment of total bypass by the diversion of all venous return into the heart-lung machine, the pulmonary artery is clamped and a longitudinal arteriotomy made. The emboli are extracted with common duct stone forceps and end-hole suction catheters. We have found that finger exploration of the pulmonary artery may be quite valuable in locating residual emboli. Although the absence of back bleeding is discomforting to the surgeon, it is not an absolute sign that there is residual obstruction. The inferior vena cava is always ligated before the decannulization, for if an embolus were dislodged during this procedure it could be conveniently removed.

The type of perfusion technique used is not as important as the speed with which it can be instituted. The low flow hemodilution hypothermic technique as described by Zuhdi for both elective and emergency cardiopulmonary bypass is used. The advantages are, first, it requires no blood for prime, and second, low flow allows the introduction of smaller catheters which can be introduced with greater facility. In any perfusion system that is to be used for emergency cardiopulmonary bypass, a nonblood prime or at least one not requiring freshly drawn heparinized blood is essential.

A combination heat exchanger, oxygenator, and reservoir for use with low flow hemodilution hypothermic technique of total body perfusion has been designed in our laboratories.[7] This unit has several advantages. First, all supplies necessary for cardiopulmonary bypass can be sterilized in one single autoclave tray. This allows the unit to be assembled in 15 minutes. Less total supply and less maintenance are minor but significant advantages.

There are four long-term survivors in this series of 14 patients. All the survivors had their embolectomies performed with the use of the heart-lung machine to provide cardiopulmonary bypass. For the patients in whom there were no significant residual emboli present, cardiopulmonary bypass was used. Also of great significance is the fact that there are no survivors over the age of 65. All nonsurvivors died similar deaths. At the end of the perfusion all were taken off the heart-lung machine with a fairly good blood pressure which persisted for only 15 to 45 minutes. Vasopressors were helpful for a period of time varying from one-half hour to two hours, then the blood pressure gradually fell despite the use of large doses of a variety of vasopressors. In each instance the blood balance was near normal, and the acid base balance was maintained at the normal range with the use of sodium bicarbonate. When necessary the patients were placed on respirators. The exact cause of death in these patients is obscure. It is our impression that the aged patient tolerates cardiopulmonary bypass poorly.

Recently an enzyme, urokinase, has been suggested for the treatment of pulmonary emboli. This is an enzymatic fibrinolytic activator and a normal constituent of urine. The exact role of this drug in the armamentarium of the physician treating pulmonary embolism is yet to be delineated. However, it appears that this will be an important contribution to the treatment of this disease.

SUMMARY

The most important single factor in the diagnosis of acute pulmonary embolism is a high index of suspicion by the attending physician. Once the disease is suspected the diagnosis can be confirmed and the location and size of the emboli determined by pulmonary arteriography.

Inferior vena caval ligation is the procedure of choice for the prevention of further embolization. This procedure is indicated whenever there is a large embolus or there are bilateral emboli.

Systemic hypotension, a reflection of decrease in cardiac output, is the indication for pulmonary embolectomy. Pulmonary embolectomy for the preservation of pulmonary function is not indicated for the majority of acute pulmonary emboli which spontaneously resolve, given enough time.

New forms of therapy to hasten the lysis of pulmonary emboli would be very advantageous.

ACKNOWLEDGMENT: The authors are indebted to the physicians of the Marshfield Clinic without whose help and encouragement this study would not be possible. The authors are especially indebted to Mr. Frederick J. Wenzel for his help with the manuscript.

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BOOKLET: ALCOHOLISM IN INDUSTRY

The Industrial Medical Association has released a booklet, "Alcoholism in Industry," which covers the methods of recognizing and managing problem drinkers in industry. The booklet also gives details on starting an industrial alcoholism program. Copies are available for $1 from the Industrial Medical Association, 55 East Washington St., Chicago, Ill. 60602.

The Incompetent Cervix

By F. J. HOFMEISTER, M.D., Milwaukee, Wisconsin

■ CERCLAGE-SUTURING of the cervix—The Shirodkar Procedure; by any name indicates a technique of lending artificial support to a cervix which cannot of itself maintain a pregnancy beyond twenty weeks. The cause may be previous obstetrical or surgical trauma or fundamental inherent tissue deficiency.

When supportive procedures are intelligently used, 60% of pregnancies, otherwise destined to be lost, will be salvaged. Forty per cent of pregnancies associated with these problem pregnancies will still be lost.

Although not completely understood and although not accepted by all obstetricians, these procedures have definite but limited value. The indications are few. Cervical incompetence is characterized by multiple early second trimester fetal losses, usually associated with sudden, painless dilatation of the cervix. Rupture of the membranes is quickly followed by expulsion of the fetus. Of those patients presenting for assistance in overcoming repeated miscarriages, relatively few fit the above category. Few can be assisted by a supportive or reinforcing procedure. Estimates indicate that the true incidence of the incompetent cervix varies from 1:350 pregnancies to as few as 1:1930 pregnancies. It is, therefore, evident that great care in selection of patients for surgical assistance is essential. Support can be given by a temporary postconceptional placement of nonabsorbable material or by a more permanent postconceptional method as advocated by Shirodkar and Barter.

When suture material is placed, exacting care and great caution is necessary so that potential hazard will be avoided. The objective of gaining a viable and healthy infant should not overshadow the dangers which can exist in this apparently simple and often over-employed procedure. Sutures should never be inserted where there is an indication of ruptured membranes. Similarly, evidence of active bleeding or dilatation of the cervix greater than 3 to 4 cm or bulging membranes are contraindications. The correct time to place sutures is not later than the 12th or 14th week of pregnancy. Sutures should always be removed when there are indications of contractions, if there is active bleeding, or when there is an indication of ruptured membranes.

Failure to heed these SIGNS FOR ACTION may result in death, not alone to the fetus, but to the mother.

Rupture of the uterus, either in the cervical areas or lower uterine segment, may be anticipated if labor is permitted without active intervention or cutting of the suture. When bleeding or ruptured membranes exist without the release of the suture and antibiotic coverage, or in the Shirodkar-type procedure, without emptying the uterus, infection and possible septic shock may result. When problems exist in either type of procedure, expert monitoring of the patient is mandatory.

A recent incident of ruptured membranes was ignored. Sutures were permitted to remain in place in an attempt to salvage a valuable pregnancy. All was lost when infection and maternal death occurred.

A second near maternal death occurred when the membranes were ruptured inadvertently while placing the suture. The existence of perforated membranes was not recognized. As soon as the symptoms of ruptured membranes occurred, no attempt was made to salvage the pregnancy. The sutures were promptly cut after the patient was admitted. By this time, 10 days after placing the sutures, the patient presented with septic shock. Only heroic methods, together with emptying of the uterus after generalized infection existed, resulted in salvage.

Has a potentially fertile woman been rendered infertile by the massive infection resulting from faulty judgment or lack of information?

These are but two known examples of the severe hazards which can occur when one attempts to reinforce the incompetent cervix. The procedure is valuable, but the physician must always remember that a major operation entails the risk of major complication.

Prepared at the request of the Maternal Mortality Study Committee of the Division on Maternal and Child Welfare of the Commission on State Departments, State Medical Society of Wisconsin. Doctor Hofmeister, a member of the Study Committee, is Associate Clinical Professor of Gynecology and Obstetrics, Marquette University School of Medicine, Milwaukee.

2212 West State Street.

Physical Therapy of the Rheumatoid Hand

By ERNEST PELLEGRINO, JR., M.D., Madison, Wisconsin

■ RHEUMATOID ARTHRITIS is a systemic collagen vascular disease involving not only joints but also such structures as muscles, spleen, and the eye. This discussion, however, will be limited to the role of physical therapy in the treatment of the hand as it is involved in rheumatoid arthritis. Emphasis should be placed on the fact that the treatment of the rheumatoid hand involves a team effort between the patient, internist, surgeon, physical therapist, and occupational therapist.

In facing the problem of treating or renovating a hand involved by rheumatoid arthritis, it is important to appreciate not only what has happened to the anatomy of the affected appendage but also the sequence in which the damage has occurred.[1] Initially, the affected joint becomes painful with or without swelling. As a result of the pain, voluntary and involuntary inhibition of associated muscles producing movement of the joints occurs. This in turn leads to disuse atrophy which may be made more severe by local inflammation. The affected joints become swollen with inflammatory exudate which affects cartilage, synovial membrane, and capsule. Because of distention of the joint by synovial fluid, the capsular ligaments may weaken and become stretched. The joint becomes unstable and so tends to subluxate. With unstable swollen joints and weak intrinsic muscles, the digits of the hands and feet are at the mercy of the long flexors and extensors, which because of the ligamentous damage around the joints and loss of synergistically acting intrinsic muscles, act in an uncontrolled fashion so that their direction of pull may deviate from normal.

Many patients show the classic picture of ulnar deviation and metatarsal deformities before there is radiologic evidence of bony erosion. The normal hand at rest shows some ulnar deviation of the index and middle fingers. During flexion and extension of the fingers, the long tendons are held in place over the metacarpal phalangeal joints by the ligamentous distal expansion acting as pulleys with intrinsic muscles acting as stabilizers, so that the pull of the long tendons is in the long axis of the digit. In a hand with swollen, perhaps unstable, metacarpophalangeal (MP) joints, wasted intrinsic muscles and damaged lax ligaments, the pull of the long tendons tends to become eccentric and the normal tendency towards ulnar deviation becomes exaggerated. Ulnar deviation is then the direct result of altered mechanical stresses.

An observant physical therapist may note basic alterations of normal movement of the rheumatoid hand long before deformities appear making it possible to prevent deformity and loss of function. The rheumatoid patient closes his hand by first flexing the MP joints and then the interphalangeal (IP) joints. Release of the grasp is achieved by first extending the IP joints. This is a reversal of the normal pattern, because the proximal interphalangeal (PIP) joints are affected first and most severely by pain on movement and the change in grasp represents the patient's attempt to avoid pain.[2]

Basically the three modalities used by the physical therapist in treating the rheumatoid arthritic patient, as well as hand, include rest, heat, and exercise. At the Rheumatoid Disease unit at the Northern General Hospital in Edinburgh, Scotland, patients who are in the acute phase with systemic and multiple joint involvement have their upper and lower extremities placed in plaster of paris splints for immobilization for a three-week rest period.[3] During this period, the patients get no physical therapy and are fed and cared for completely by the nursing staff. During the fourth week they can move about in bed with the splints bandaged on at night. After the fourth week, their activity is progressively increased.

In the patients with longer standing rheumatoid arthritis where there are signs of activity in a specific joint or joints, the affected limb is immobilized while the remaining limbs are exercised. When the unaffected joints are not being exercised they are immobilized in gutter splints for three

Doctor Pellegrino is an orthopedic resident at University Hospitals.

weeks, during which time the patients get up for toilet and bathing purposes and have physical therapy, which takes the form of a class of basic maintenance exercises once a day and specific joint exercises twice a day. During the next two weeks, the patients start to sit out of bed for increasing lengths of time and start to walk with or without aids as required. During the sixth to seventh week, the patients start weight-bearing exercises in the department. The "rest" group or the acute cases go through the same routine, but are two weeks behind. The basic maintenance exercise class is designed to move as many joints as possible through as full a range as possible, exercising not only limb muscles, but the large trunk muscles as well.

The specific joint exercises at the Northern General Hospital Rheumatic unit always take the form of free, active exercises or weight-resisted exercises, never passive. They feel that passive movements undo the benefit gained by resting a joint because they tend to lead to a protective muscle spasm and also invariably produce an effusion.

The use of properly fitting splints is felt by Dunlap to be probably the most important advance yet made in the management of the joints in rheumatoid arthritis.[4] The function of the splint is to protect and immobilize the acutely inflamed tissues with the ultimate aim of preserving a movable and functionally useful joint. Ideally a splint should be light, comfortable, and easily removed. The joints as positioned in the splint should be as follows: *Hand and fingers*—a slight degree of flexion with approximately 25° at the MP joint and curved to prevent ulnar deviation; *wrist*—30° to 45° extension; *elbow*—100° flexion midway between pronation and supination; *shoulder*—slightly flexed at approximately 30° with 45° abduction and 15° external rotation.

The use of some form of heat preceding a course of exercises is commonly used in most departments of physical therapy; the reasons given are that heat improves muscle relaxation, increases the blood supply, and decreases awareness of the pain. Whirlpool or paraffin baths are used most extensively for this purpose. Water is restricted by the temperature at which it can be used, whereas paraffin can be used safely at higher temperatures (128 F for paraffin as compared to 110 F for water). However, water has the advantage of making it possible to exercise the hand while heat is being applied.[2]

Recently Harris and Millard raised significant doubt as to the value of paraffin wax baths and packs.[5] They assessed the patients initially and weekly for pain, tenderness, swelling, grip, and dexterity and concluded that after three weeks of treatment five times per week there was no difference between the group receiving no local treatment and those receiving treatment; however, at six weeks there was slight improvement in the group treated for this length of time. The authors suggested that better results might be obtained by the method of citrate iontophoresis as described by Coyer. Iontophoresis by definition is the introduction by means of electrical current of ions of soluble salts into the tissues of the body for therapeutic purposes. The rationale behind using citrate which is an anticoagulant is as follows: Although the exact mechanism which causes the joint and periarticular lesions in rheumatoid arthritis is not known, most authorities consider local hypersensitivity to be the likely cause. In allergic and anaphylactic reactions, clumps of leukocytes and platelets are found in capillaries and in small blood vessels. These micro-emboli break up quickly followed by the release of histamine substances. Citrate acting as an anticoagulant prevents the agglutination of the cells and thus halts the final release of histamine. Improvement is frequently seen in patients after their first treatment lasting for three to four hours.[6] The use of paraffin wax and packs in treating rheumatoid arthritic patients is the exception rather than the rule at the Rancho Los Amigos Hospital in California.[7]

Once ulnar drift has occurred, bracing and physical therapy will not correct the deformity since the extensor hood and ligaments are stretched. Therefore, treatment during the early stages should be directed toward exercise to strengthen the intrinsic muscles. The extensors should be strengthened and the MP joints stretched into full extension to prevent contractures and subluxation. Strengthening the intrinsic muscles can be achieved by placing an elastic material between the patient's fingers and teaching him to squeeze them together. The patient should place his hand palm down on a flat surface to insure that he is using the intrinsic muscles and not substituting the finger flexor

pattern. The function of grasping will be performed in the proper plane if the patient uses a rolled elastic bandage rather than a rubber ball. Wooden rollers are also an excellent device to train the patient in grasp and finger flexion. In strengthening the patient's pinch between the thumb and one or more of the fingers, having the patient tie strings, ropes and ribbons into knots is useful. Tearing pieces of newspaper or cloth can also be used to advantage for this purpose.[2]

The tightness of the intrinsic muscles will be evident if a swan neck deformity begins to develop. This contracture should be treated by active assistive exercises with the MP joint at 180° and forced flexion of the PIP joints. The Bunnell knuckle bender splint with an extra flexion segment may be used to assist these patients.[8] Williams emphasizes the use of artificial aids in patients who have difficulty in voluntary movement of their joints.[1] He feels that faradism or rapidly alternating current may be used in reeducating and strengthening the intrinsic muscles. The author felt that with the patient's cooperation, a stronger muscle contraction could be elicited than that produced by the patient alone; and even if the patient were completely uncooperative, faradism could produce sustained contraction.

The importance of the wrist to the hand in the rheumatoid patient cannot be overemphasized since the typical volar deformity causes a decrease in the mechanical efficiency of the flexion component of the fingers. A fault often occurring in training of the wrist extensors is that the patient will augment movement by using the long extensors of the fingers. The patient should be taught to flex the fingers as he extends the wrist, even during simple range of motion exercises. Frequently the flexor muscles along with the force of gravity precipitate a volar flexion deformity of the wrist and fingers. The use of night splints, bandaging, and functional wrist splints during resting hours have proved beneficial as preventative measures to eliminate stress and prevent the deformities from occurring.[2]

P. Hume Kendall prescribes the following exercises for the rheumatoid hand and wrist.[4] Each IP and MP joint is flexed and extended passively with the opposite hand. Each joint of each finger and thumb is then flexed and fully extended actively. The whole hand then performs a gripping movement, relaxes and then is fully extended again. The hand is placed flat on the table with the palm downward. The palm is raised and an attempt is made to force the fingers and palm into the table, flexing from the MP joints with the IP joints fully extended. The hand is placed flat upon the table, and the fingers are stretched as far apart as possible and then squeezed tightly together. *For the wrist,* the forearm rests on the edge of a table with the palm down and the hand over the edge. The wrist is flexed as fully as possible, relaxed, extended about 10°, and then flexed as fully as possible again. The forearm rests on the table with the palm down and the hand is deviated radially first and then to the ulnar side as far as possible and then brought back to the midline. The forearm and hand rest on a table with the elbow flexed to 90° and the palm facing downward. The wrist is extended as fully as possible, then relaxed, flexed 10°, and finally extended as fully as possible again. Kendall states that at the same time that mobilizing exercises are practiced, a series of exercises must be included to develop power in the muscles that support the affected joint. This is done with progressive resistive exercises. In the earlier stages of exercise gravity alone may be adequate resistance.

The physical therapist plays an important role in the preoperative evaluation of the rheumatoid hand as well as the postoperative therapy.[9] Measurements of all the digital joints during active and passive flexion and extension movements are made preoperatively. In addition measurements of the ulnar drift of the digits, wrist flexion and extension, and radial or ulnar deviation are made. The strength of the hand is also measured by means of a dynamometer which records grasp and pinch grip. Probably more important is the specific manual muscle testing performed by the therapist. The pinch assesses opposition of the thumb as well as the power of flexion of the opposed finger at the MP and PIP joint.

The surgical procedures involving the rheumatoid arthritic hand include synovectomy, tendon suture, arthroplasty and insertion of a joint prosthesis. Following surgery while the patient's hand is usually elevated in a stockinette holder, the shoulder and elbow joints are moved as fully as possible. Synovectomies may be done during the early or late stages of the disease.[9] When done

during the late stage of the disease, the procedure is mainly a salvage type operation which is not very successful because there has already been considerable damage to the joint. However, some patients do get relief of pain and increased joint range with some improvement in function. When done in the early stage there is a much greater likelihood for success as there is very little if any joint damage and only slight muscle imbalance. It is important for the physical therapist to check the balance of muscle power and strengthen any weakness, particularly in relation to synovectomies of the MP joint.

Following a synovectomy the hand usually is protected in a bulky dressing for 10 days to permit healing, but motion is started early to regain as much function as possible. Active and passive motion of the MP joints are begun and the patient is instructed in exercise similar to the previously described preoperative program. As soon as the stitches are out, paraffin baths and hydrotherapy can be started. A plaster night splint is frequently worn on the ulnar side to prevent recurrent drift. About three weeks postoperatively the Bunnell knuckle splint is used to assist the patient to gain flexion and a reverse knuckle bender to gain extension. The splint should be worn for only 5 to 10 minutes several times per day to prevent undo pressure on the incision from the brace.

Tendon suturing of the rheumatoid hand is done for attritional ruptures which usually involve the extensor tendons particularly of the little finger and middle finger.[9] After it has been sutured, the tendon is fixed for 4 to 5 weeks in the shortened position. Gradual gentle physical therapy is introduced starting contraction of flexors in the outer range, thus giving reciprocal relaxation of the extensors. If a muscle works over more than one joint, it must be kept in the shortened position over one joint while it is being stretched over the other. Following the reciprocal relaxation, contractions of the extensors are started in the inner range and then carefully progressed through range. Once range has been gained resistance is introduced and given to the hand and whole arm using proprioceptive neuromuscular facilitation techniques.

Following an arthroplasty, the same postoperative treatment routine is indicated for the patient as for one who has had a synovectomy.[9] After arthroplasty many patients have difficulty in extending the fingers fully because the metacarpals have been surgically shortened while the extensor communis tendons remain the same length. Electrical stimulation is of value here and can also be used as a reeducational tool in getting the patients to use transplanted tendons. The patients are taught to become aware of the position of the hands both during use and at rest as gravity can be very instrumental in increasing ulnar deviation. If exercises such as wringing wet clothes tend to encourage ulnar drift the patient is instructed to avoid such activities.

Patients who have a Flatt prosthesis or articulated metallic hinge substituted for a grossly destroyed or dislocated digital joints of the hand require physical therapy postoperatively.[10] Adrian Flatt points out that the therapy varies with location and number of prostheses inserted. For the metacarpal phalangeal prosthesis the following regimen is outlined. The patients come back from the operating room with the joints fully supported in extension, usually with a palmar plaster slab. After 7 to 10 days, this support is changed to a palmar disk to maintain the functional position of the hand while it is not being treated. The disk is attached to a ¼ inch board the length of the forearm maintaining the wrist in extension and the fingers in slight flexion. After the surgeon feels all the signs of the immediate reaction to surgery have settled, electrical stimulation is started on the extrinsic extensors—usually within 48 hours. Stimulation is centered mainly around the extensor digitorum communis, extensor indicis, and extensor digiti quinti muscles. Following the location of the basic motor points a surging AC current is used to initiate an isometric contraction in the above muscles. Isometric contraction is necessary because digital movements are restrained by the bandages and cast until the early healing phase is complete. Four to 5 days later when isotonic contraction is feasible, the extension movement in the MP joint is initiated by positioning of the MP joints in flexion over the edge of a table with stabilization by the physical therapist on the wrist and metacarpal bones. If a satisfactory motion is not being obtained, the extensor tendons are put on a more severe stretch by placing the wrist in flexion over the table edge with stabilization as in the above procedure. The stabilization at the wrist and

metacarpal bones permits the digital extensor muscles to act fully as finger extensors with the main action taking place at the MP and PIP joints. As the patient begins to gain the feeling of the specific muscles used for finger extensors, he or she is encouraged to actively assist the contracting action of the electrical stimulus. Gradually as the patient gains more voluntary motion and strength, the intensity of the electrical stimulation is decreased proportionally until the patient is actively performing the motions independent of the electrical stimulus.

When a PIP joint prosthesis is used, the fingers and wrist are kept in a half cast covering the volar surface from the forearm to just beyond the terminal phalanges.[10] The cast is replaced with a disk at 7 to 10 days. The patient begins as of 24 to 48 hours postoperatively with electrical stimulation of the extensor digitorum communis, extensor indicis, and extensor digiti quinti to reeducate the patient's proprioceptive centers and initiate motion in the corrected joints. Stabilization is applied at the wrist and proximal phalanges, and the PIP joints are flexed over the edge of the table.

When a thumb metacarpophalangeal joint prosthesis is used, the thumb extensors (extensor pollicis longus and brevis) are stimulated for isometric contractions along with electrical stimulation of the finger extensors in the early healing stage 4 to 5 days after surgery. Later isotonic contractions are begun after the bandages and casts are removed.[10] Gradually the patient assists the electrical stimulus until maximal motions are completely voluntary in both flexion and extension of the MP joint.

In the next phase the exercises are directed toward improvement of the fingertip and grip prehension.[10] The reason for reeducating and strengthening the extrinsic extensors is that at the time of the prosthetic placement the intrinsic muscles are released because of their weakness, scarring and contracture tending to create the finger deformity. After the patient has gained satisfactory motion of the prosthetic joints a home program is set up with specific exercises consisting primarily of domestic procedures for the female aimed at range and improving muscle strength. The occupational therapist works with the patient on this aspect before discharge. The male patients have a more directly supervised program and the exercises are kept on a masculine basis. Once useful function has been obtained, more difficult tasks are slowly added to complete the rehabilitation program prior to the patient's return to his old occupation or new one found more suitable for his ability by vocational evaluation.

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ADVERSE REACTION—COINCIDENTAL OR CAUSAL?

Thus we see that panic, misinterpretation, or just plain ignorance still form the basis of judgments about the safety of our newer drugs. Clinicians are still not used to thinking in terms of the huge number of individuals taking a particular drug, and the opportunity this affords for coincidental events which may be mistaken for causal relationships. If physicians do not keep this inevitable possibility in mind, they may end up treating coincidences instead of patients—an occupation of doubtful utility and poor prognosis.—Joseph W. Goldzieher, M.D., in *Texas State Journal of Medicine*, (62:37), May 1966.

BOOKLET: MANITOWOC STORY

The Wisconsin State Board of Health, in cooperation with school personnel, conducted a study of the Manitowoc school health program. The philosophy underlying the study and the method of procedure, as well as the findings, have been published in "Manitowoc Story: A Team Approach to a School Health Study."

The booklet was written by Virginia Hull, school health consultant, Betty Krippene, dental health consultant, and Frances Porter, maternal and child health consultant for the Section on Community Health Services, Wisconsin State Board of Health, District Office No. 3, Fond du Lac.

Surgical GRAND ROUNDS NO. 12 OF A SERIES

UNIVERSITY OF WISCONSIN MEDICAL CENTER

Co-Editors:

ROBERT C. HICKEY, M. D.
Professor and Chairman, Department of Surgery

LOUIS C. BERNHARDT, M. D., Resident in Surgery

Surgical Grand Rounds are conducted weekly as a portion of the University of Wisconsin Medical Center program in surgical education. This conference is held at 4 PM on Wednesdays in Room 300, University Hospitals, and guest physician participation is invited. Cases presented at the Grand Rounds will be published in a selective manner periodically in the WISCONSIN MEDICAL JOURNAL.

MANDIBULAR FRACTURE

Discussants: JOHN SADD, M.D.
THEODORE FEIERABEND, M.D.

CASE PRESENTATION

Dr. Dan Fox: Today we are presenting two cases of mandibular fractures. Each was sustained in the most common manner, and each resulted in the most common type of multiple fractures.

The first patient was involved in a fist fight on July 9, 1966, resulting in a direct blow to the chin. Upon examination, the local physician diagnosed mandibular fracture and referred him to University Hospitals, where he was admitted to the Plastic Surgery Service on July 11. History was essentially negative. Physical examination showed swelling and extreme tenderness around the face. There was a palpable fracture on the left side at the angle of the mandible. We felt that there was also a fracture on the right side of the body near the mental foramen. X-ray films proved this diagnosis to be correct.

The second patient was involved in an automobile accident in which he was thrown against the front of the dashboard. His local physician, deciding that he had mandibular fracture, referred him to University Hospitals on July 14, where he was admitted to the Plastic Surgery Service. He had a displaced fracture in the body of the mandible on the left side near the mental foramen; we felt that there was also a fracture on the right side, but could not localize it by palpation. X-ray films showed a fracture of the right condylar neck.

DISCUSSION

Dr. John Sadd: We've used these two patients today to emphasize that we see between 25 and 30 cases of mandibular fracture every year.

From the Section of Plastic Surgery.

First, it is important to know the anatomy of the mandible. The body of the mandible consists of inner and outer dense cortical bone, with a thin layer of spongiosa in the middle. Through this run the alveolar nerves and vessels. The body joins the ramus at the angle of the mandible. Considerably thinner than the body, the ramus also has dense cortical bone on both inner and outer tables. Under the coronoid process are attached the muscles of mastication. The condylar process articulates at the glenoid fossa of the temporal bone. The junction between the two mandibular bodies is known as the symphysis.

The anatomy of the mandible renders it very susceptible to fracture in certain areas, other areas being quite uncommonly fractured. The most common fracture occurs at the neck of the condylar process, the so-called condyle. Another common fracture is the angular fracture, occurring at the junction between the body and ramus. A third common type of fracture occurs through an impacted third molar. It has been estimated that about 25% of the adult population of this country have impacted third molars. The fourth common type of mandibular fracture occurs through the mental foramen. It will be recalled that the inferior alveolar nerves run through the body of the mandible and exit at the mental foramen. This creates a weak point in the bone. A fifth fairly common type is the alveolar fracture, usually resulting from a direct blow which, while not fracturing the entire mandible, will break loose two or possibly three teeth along with the accompanying segment of alveolar bone.

The cause of mandibular fracture is usually direct trauma. Other causes include pathologic fractures from benign or malignant neoplasms, bone cysts, and hemangiomas. Occasionally a fracture will result

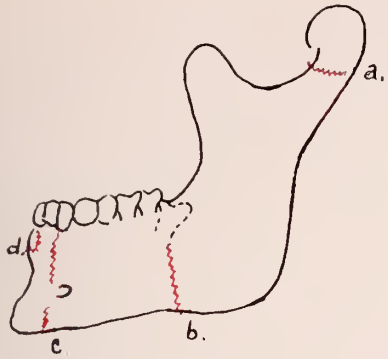

Fig. 1—Comman sites af mandibular fractures.

Key: a. Condylar fracture
b. Molar fracture
c. Mental fracture
d. Alveolar fracture

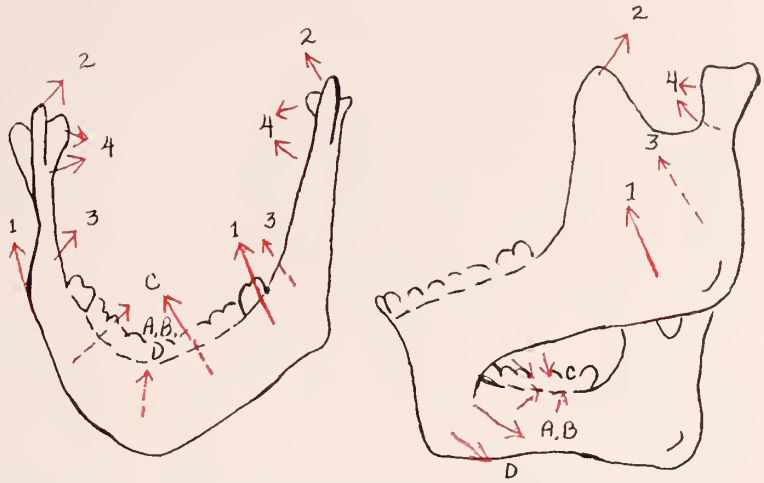

Fig. 2—Muscles of clasing and opening.

Key: muscles of closing:
1. Mosseter
2. Temporalis
3. Medial Pterygoid
4. Lateral Pterygoid

muscles af apening:
A. Geniohyoid
B. Genioglossus
C. Mylohyoid
D. Digastric

from a tooth extraction, usually at the molar level.

Certain blows to the mandible will cause certain fractures. A blow directly anterior on the point of the chin usually causes a bilateral condylar fracture involving both condyles. An oblique blow to the side of the jaw usually causes a fracture at the site of impact and a contralateral fracture at the opposite condyle. A direct lateral blow of significant force can result in a single fracture immediately beneath the point of impact.

There are various types of mandibular fractures. The usual orthopedic classifications are applicable: the green stick fracture, the simple fracture, an open fracture, a depressed fracture, a rotated fracture, and so on. The alveolar fracture usually results from a direct blow and can be difficult to diagnose.

Of the many methods of classification, one is especially important. This is done according to the presence or absence of teeth on one or both sides of the fracture. From the standpoint of treatment, this is especially important. The Class I fracture is one on which there are teeth on both sides of the fracture; the Class II fracture has teeth on only one fragment. The latter includes fracture through an impacted third molar. The Class III fracture takes place in an edentulous jaw. It should be pointed out that the teeth normally lend a certain amount of stability to the mandible; thus, fractures are more common in edentulous or Class III jaws.

The symptoms of mandibular fractures are reasonably well known. There is pain, swelling, and increased salivation. This last is caused by nerve stimulation from the fracture. Often there is disability; the patient is unable to speak normally or eat normally. Most important is the symptom of malocclusion. As it is frequently difficult to be determined clinically, malocclusion is usually detected by the patient.

The signs of mandibular fracture are: tenderness directly over the fracture site, crepitation on motion of the mandible between two fingers, ecchymosis over fracture site, and mandibular dysfunction. The patient may be unable to fully open his mandible; on the other hand, he may be able to open it widely, but with deviation of the mandible, usually toward the site of fracture.

The diagnosis of mandibular fracture is usually made by x-ray. Most common x-rays ordered are anterior/posterior (AP) and both laterals; these should show the fracture. The scanogram is often used to x-ray fractures; we have seen two fractures today that were not demonstrated by this technique. In the case of alveolar fracture, it may not show up with just the AP and laterals; the occlusal view will usually demonstrate it. Occasionally, dental x-rays are

helpful. One should insist upon a direct AP and two lateral views of the jaw.

Dr. Theodore Feierabend: In discussing the treatment of mandibular fractures, it is interesting to note that this injury dates back to very ancient times. Some of the early papyri which discussed medical problems warned physicians and ancient healers not to treat mandibular fractures. The patients suffered from a high incidence of infection, and the physician suffered from a resultant bad name. The earliest recorded description of treatment of mandibular fractures is about 600 B.C., when the Etruscans used gold wire or linen thread to wire teeth together.

The aims of treatment are the same as for any fracture. The primary aim is to *reduce* the fragments. As Doctor Sadd mentioned, the dental status of the patient is of great importance in accomplishing this aspect of treatment. Alveolar fractures having a portion of the alveolar bone attached to several teeth can frequently be reduced manually, with a single wire holding the bone in place. Where there is an edentulous quarter or more of the mouth, the treatment is greatly complicated.

Another goal, of course, is to *avoid complications.* Muscle pull can complicate immobilization. Control of infection is important, although with prompt and modern surgical treatment, infection is relatively rare. Oral hygiene has to be maintained. Because the patients cannot adequately swallow and masticate, they cannot keep the mouth clean. Fractures through an impacted tooth usually require the removal of that tooth to prevent infection.

Muscle pull can complicate treatment. The masseter muscle, attached to the angle, pulls both upwards and anteriorly, while the temporalis muscle pulls upward and posteriorly. The medial pterygoid pulls upward, inward, and anteriorly, and the lateral pterygoid, with its two muscle bundles, has similar pull. If the condyle is broken between the two muscle bellies, however, the muscular attachment to the condylar head and to the joint capsule will result in a downward pull. The geniohyoid and the genioglossus, opening the mouth, pull directly backward and downward. The mylohyoid, attached along the body, pulls both inward and downward, and the digastric, attached at the symphysis, has a downward pull. If the fracture is in the body, these two muscle groups will tend to pull the distal fragment downward and the proximal fragment upward.

Thus, the condylar fracture is displaced medially. A fracture at the base of the coronoid process is held in good alignment, and usually very little displacement is seen because of the muscle bodies on either side of the coronoid holding it in this frontal position. A fracture at the ramus of the angle is pulled upwards and inwards. Displacement due to fracture through the body is very variable, and depends upon the location of the fracture and the muscles still attached. Alveolar fractures, having no muscular pull, have a very minimal displacement; if displacement is present, it is the result of the trauma.

The mandible is unusual in that it has external attachments directly to the bone useful for manipulation and maintenance of immobilization. Interdental wiring is one method of treatment. It is used mostly for localized alveolar fractures, the wires being placed around adjoining teeth. Occasionally, a fracture to the entire body can be immobilized by wiring two teeth on either side of the fragment to each other, splinting the fracture. This is a rare type of treatment, however. More frequently, a monomaxillary splint is used. The use of intermaxillary splints, in which metal splints are applied to both upper and lower dental arches, the mouth is placed in normal occlusion, and the two arches wired together in occlusion, is the best method for immobilizing mandibular fractures. Occasionally, with multiple fractures, the fragments will not align properly and the occlusion will not be satisfactory. In this case, interosseous wiring is necessary. Capping the teeth and other complex external appliances are used more in Britain than here in America. We usually find that either the intermaxillary or the interosseous wiring is adequate.

Complications of mandibular fractures can occur either early or late in treatment. The early complication of hemorrhage is usually related to the soft tissue injury. Very rarely is hemorrhage from the alveolar artery seen. Respiratory obstruction may occur as a result of loss of control of the tongue, which falls to the back of the throat. After the teeth have been wired shut, there is the danger of vomitus aspiration. Infection may result in osteitis or avascular necrosis of the bone, ultimately forming osteomyelitis and, sometimes, ankylosis of

the mandible in a fixed position. Later complications of non-union usually result from separation of the fragments, either by interposition of soft tissue or by loss of a fragment of bone. Non-union may also result from infection and, occasionally, from debility of the patient to maintain nutrition while teeth are wired together. Mal-union will result from either poor reduction or poor fixation of the fracture.

The second patient presented today suffered his fracture on July 14. He had interdental intermaxillary wiring using Erich arch bars. These are applied to both upper and lower dental arches with wires placed around each tooth to hold the arch bar in place; generally it is done under general anesthesia here at University Hospitals. The patient should be adequately premedicated and starved previous to operation to produce an empty stomach, thus helping to avoid problems with aspiration. They should not be started on alimentation for perhaps 24 hours postoperatively to ensure that emesis does not occur. They should also be warned of the danger of taking alcoholic beverages postoperatively until the wires are removed.

Doctor Sadd: The first patient had a similar fracture. He presented one of the early complications of mandibular fractures: one fracture was through an impacted third molar, with an abscess which was drained intraorally.

Doctor Feierabend: There is an additional method of treatment. This is Kirschner wire fixation, which can be used in conjunction with some of the other treatments. Barton bandaging might be adequate in a child.

Dr. Walter Schwindt: If a person with false teeth sustains a mandibular fracture, do you usually wire them with their plates in place?

Doctor Feierabend: Yes, the plate itself can be used as a device for immobilization. It can be fixed by wiring either around the mandible or into the upper alveolus. One can also just place the plate in the mouth and use a sling wire from the zygomatic arch to the mandible.

Dr. Robert Hickey: It is interesting that the two patients presented today represent the two most common causes of mandibular fracture. One received a direct blow to the jaw; the other struck his head on the dashboard of an automobile.

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CLINICAL CENTER STUDY OF DISEASES OF CALCIUM METABOLISM

The cooperation of physicians is requested in a continuing clinical study of calcium metabolism and calcium kinetics being conducted by the Metabolism Branch, National Cancer Institute at the Clinical Center, National Institutes of Health, Bethesda, Md.

Of interest for this study are patients with calcinosis universalis, hypoparathyroidism, hyperparathyroidism, pseudohypoparathyroidism, and hypercalcemia of malignancy without bony metastases. Patients with roentgenologic evidence of bone disease as well as documented serum calcium abnormalities would be of special interest.

Patients for this study should be clinically stable, ambulatory, continent of urine and feces, and be willing to participate in metabolic balance studies, including administration of Ca^{47}, during a 30-day admission to the Clinical Center.

Physicians interested in having their patients considered for this study may write or telephone: James M. Phang, M.D., Clinical Center, Room 3B-40, National Institutes of Health, Bethesda, Md. 20014. Telephone: 656–4000, Ext. 63097, area code 301.

FILM: TECHNIQUE OF PLATELET TRANSFUSION THERAPY

A motion picture demonstrating a medical technique that is substantially reducing leukemia deaths due to hemorrhage has been released by the Acute Leukemia Task Force of the National Cancer Institute. The film, titled "Technique of Platelet Transfusion Therapy," was prepared as orientation material for blood bank personnel by the Task Force at the National Institutes of Health, U. S. Public Health Service.

The film presents a step-by-step demonstration by a hematology technician of the platelet separation process, and portrays a family's role in contributing to a leukemic child's well-being through platelet transfusions.

The 16-millimeter color production, running time 21.75 minutes, was made with assistance from the American Red Cross, the District of Columbia General Hospital, and the Clinical Center of the National Institutes of Health. Requests to borrow the film without charge may be addressed to the U. S. Public Health Service Audiovisual Facility, Atlanta, Georgia 30333.

Presented by the Wisconsin Society of Pathologists
S. L. Inhorn, M.D., Madison, Chairman of the Publications Committee

Use of a Frozen Control in Hemoglobin Determination

By ROLAND E. BERRY, M.D. and SISTER M. DE LOURDES, O.S.F., M.T. (A.S.C.P.)
Escanaba, Michigan

■ THE RELIABILITY of the hemoglobin determination has long been a subject of concern to pathologists in particular, and physicians in general. With the advent of a reliable cyanmethemoglobin standard, many of the problems of accuracy inherent in older methods were resolved. Reproducibility, however, has continued to be a problem as evidence in the introduction to the report of Beeler, et al,[1] where reproducibility of plus or minus 5% to 40% has been found in various laboratories. Sunderman is quoted as stating that "with careful check on standards it is possible to hold error to plus or minus 10%."

The problem of reproducibility can best be stated as the question: "If the patient's hemoglobin has not changed, what variation can be expected in the reported hemoglobin value today and three days from now?" If Sunderman's 10% variability is taken and the patient's hemoglobin is 14.5 gm per 100 ml, then the expected laboratory variation is plus or minus 1.5 gm per 100 ml. Many quality control programs[1,3] utilize duplicate samples of patient blood to arrive at their variability expressed as a standard deviation. Such duplicates, done on the same day (and perhaps by the same technician) do not take into account the effects of variables which may be present in the laboratory from day to day that are not necessarily present within a single day. That such variables exist is clearly demonstrated in our recent study of duplicate versus day to day unknowns in blood chemistry.[2]

For several years we have been using hemoglobin solutions (diluted with pooled patient serum and stored at —30 C) as daily unknown pools in the quality control of the hemoglobin determination. Standard deviations and coefficients of variation derived from repeated determinations on these pools, give us a measure of the variability of results due to variables within the laboratory itself and includes day-to-day variables. The preparation and use of these pools are described in this report.

MATERIALS AND METHOD

In preparing the pools, oxalated blood left over from the daily hematology specimens is pooled and centrifuged. The plasma is removed with a capillary pipette and the residual blood cell mass is poured into a small polyethylene bottle and frozen in the deep freeze which is adjusted to maintain a temperature of —30 C. Additional red cell mass is added until 50 to 150 ml of frozen, concentrated blood is obtained. The frozen blood is then allowed to thaw at room temperature which results in hemolysis of the red cells. The hemolyzed solution is centrifuged and decanted in conical centrifuge tubes to remove the red cell stroma, leaving a concentrated hemoglobin solution which has a hemoglobin concentration of approximately 20 gm per 100 ml. Using pooled patient serum as a diluent, pools are prepared by making appropriate dilutions such that the resulting volume of each pool is at least 50 ml. As an example, if a pool is desired that has a concentration of approximately 4 gm per 100 ml, 10 ml of the concentrated hemoglobin solution would be diluted to 50 ml with pooled patient serum. If 20 ml of the concentrated hemoglobin solution is diluted to 50 ml, the resulting pool will have a concentration of approximately 8.0 gm of hemoglobin per 100 ml. The final concentration, therefore, of the pools depends upon (1) the dilutions prepared and (2) the degree to which the plasma is re-

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TABLE 1—*Consecutive values of Pool H-16*

1—12.3	11—13.0	21—12.3	31—13.4
2—12.6	12—13.0	22—12.5	32—11.7
3—12.3	13—13.0	23—12.3	33—12.6
4—11.6	14—12.6	24—12.0	34—12.5
5—11.7	15—12.0	25—12.5	35—13.6
6—12.0	16—12.3	26—12.5	36—12.6
7—13.0	17—13.0	27—11.9	37—12.6
8—12.3	18—12.5	28—12.1	38—12.3
9—12.6	19—13.2	29—12.3	39—13.0
10—13.2	20—12.8	30—12.0	40—13.0

moved from the blood in preparing the concentrated hemoglobin solutions.

Occasionally mixing serum and concentrated hemoglobin solution produces clot formation. When this happens the clot is broken up with applicator sticks or by shaking with glass beads, and the diluted hemoglobin solution is centrifuged and decanted to remove the clots before distribution into test sample tubes.

Pools prepared in this manner are distributed in 0.5 ml test samples in small serology tubes and stored in the deep freeze at —30 C. Since we use these pools as daily unknowns, the individual tubes are not labeled. The container in which they are stored is given a pool identification number. At least six pools are available from which the daily unknown is selected at random. On the night before testing, a sample is removed from the deep freeze by the pathologist or the chief technologist and placed in a designated place in the standard reagent refrigerator. In the morning the sample is removed from the refrigerator by the technician on duty in hematology and the hemoglobin is determined with the morning run of patient hemoglobins. Since we are currently studying within-day variability in the laboratory, we also select a second sample tube from the pools to be run with the afternoon hemoglobins.

The report on the unknown for the day is given to the chief technologist or pathologist and is entered on the wall graph for the pool from which it came. After 20 determinations are obtained on a specific pool, the mean value and standard deviation for that pool is calculated. Since the pool concentration each day is unknown to the technician doing the hematology, the standard deviations derived from the pools can be taken as a measure of the overall variability of the laboratory in repeated hemoglobins done on patients (who are also unknowns done over the same period by the same group of technicians using the same method).

TABLE 2—*Mean Value and Standard Deviations of Hemoglobin Pools*

Pool No.	Period Ending	Mean Value	S.D.	Period Ending	Mean Value	S.D.
H- 1	3-26-65	3.4	0.34	6- 2-65	3.0	0.25
H- 2	3-26-65	6.8	0.40	6- 1-65	6.2	0.64
H- 3	3-26-65	8.5	0.33	6- 3-65	7.8	0.46
H- 4	3-26-65	10.3	0.84	5-21-65	9.8	0.62
H- 5	3-26-65	13.3	0.61	6-11-65	12.7	0.52
H- 6	8- 7-65	17.4	0.53	11- 4-65	18.3	0.52
	2-14-66	18.0	0.69	3-29-66	18.4	0.60
H- 7	8- 6-65	15.0	0.63	10-25-65	15.8	0.60
H- 8	8- 3-65	12.4	0.49	11-22-65	12.9	0.27
	3- 3-66	12.8	0.33			
H- 9	8- 4-65	4.3	0.35	11- 2-65	4.5	0.45
	1-17-66	4.3	0.18			
H-10	11- 8-65	9.7	0.67	2-22-66	9.3	0.38
H-11	10-29-65	9.9	0.38	2- 8-66	9.5	0.46
H-12	11- 9-65	12.6	0.45	3- 4-66	12.1	0.50
H-13	7-11-66	15.7	0.54			
H-14	8- 4-66	16.7	0.61			
H-15	6-29-66	14.4	0.64	9-27-66	14.8	0.44
H-16	7-11-66	12.5	0.48	9-30-66	12.4	0.49
H-17	7-16-66	11.7	0.47			
H-18	7-18-66	9.2	0.56			

RESULTS

Table 1 lists the consecutive values obtained on one of our current pools between Mar. 6 and Sept. 30, 1966. The mean values in this pool on the first 20 determinations was 12.5 gm per 100 ml with a standard deviation of 0.48 gm per 100 ml. The second series of 20 determinations (between July 7 and September 30) gave a mean value of 12.4 gm per 100 ml and a standard deviation of 0.49 gm per 100 ml. It is to be noted that no individual value on this pool during the entire period exceeded 2 standard deviations from the mean. In our laboratory, any value significantly exceeding 1 standard deviation from the mean is considered a probable technical error until proven otherwise. Both the reading of 13.6 and 13.4 gm per 100 ml in this series are two such points.

Table 2 gives the mean values and standard deviations obtained on the 18 pools used since Jan. 1, 1965. During this period of nearly two years the hemoglobin procedure was modified at least three times. Early in 1965 the Sahli pipettes (presumably for the first time) were calibrated photometrically. Subsequently the Sahli pipettes were abandoned in favor of an automatic diluting pipette. Late in 1965 the reading of the hemoglobins was transferred from a Leitz photometer to a Coleman Jr. spectrophotometer.

It is quite clear that these changes in technique resulted in more reproducible results. Throughout 1965 the standard deviations for pools with mean values under 10 gm per 100 ml were 0.35 to 0.40 and for pools over 10 gm generally exceeded 0.50. Throughout 1966 the standard deviations have rarely exceeded

TABLE 3—*Stability of Pools*

Pool No.	Period Ending	Mean Value	S.D.	Value on 10-18-66
H-1	3-26-65	3.4	0.34	3.5
	6- 2-65	3.0	0.25	
H-2	3-26-65	6.8	0.40	7.5
	6- 1-65	6.2	0.64	
H-3	3-26-65	8.5	0.33	8.9
	6- 3-65	7.8	0.46	
H-4	3-26-65	10.3	0.84	12.1
	5-21-65	9.8	0.62	

0.50 gm in pools over 12.0 gm per 100 ml. Even so, it is evident that there is room for improvement in our reproducibility.

In Table 3 the mean values of 4 pools derived in March 1965 are compared with one isolated reading on samples of each pool on Oct. 18, 1966. It is evident that there was no deterioration of the hemoglobin during this period of one and one-half years. It would appear that the values were slightly higher at the end of this time. Reviewing the day to day values obtained prior to Mar. 26, 1965, for pool H-2 shows four values above 7.0, one of which was reported as 8.3 gm per 100 ml. In pool H-3 there were four values of 9.0 or above in the period prior to Mar. 26, 1965. In pool H-4 there were no values above 11.0 gm per 100 ml in the series from which the standard deviation was calculated in March. The sample of this pool which was tested in October 1966 had lost the plastic stopper while in storage. This suggests the possibility of evaporation during storage which could account for the higher value after a year and a half of storage.

DISCUSSION

To evaluate the overall reproducibility of a laboratory where several different people of variable training do the hemoglobin determination requires that the test material approximate that of patient material and be reasonably stable over the test period. Hemoglobin derived from hemolyzed red cells and suspended in serum as a diluent has proven satisfactory in this respect. Since we normally use any specific pool for not much more than 9 months, and since there is relatively little alteration of the pools over an 18-month period, the stability of these solutions does not appear to be a serious problem.

If the overall reproducibility of the laboratory as measured by hemoglobin pools is to be taken as the reproducibility one could expect in repeated patient values, the concentration of the pool must be truly unknown to the technician doing the testing. This can be readily accomplished by carrying six or more pools of different mean values, yet mean values close enough that some of the individual values can be expected to be found in more than one pool. If the identity of the pool sample for the day is withheld from the person doing the testing, then the sample becomes a true unknown in the same sense as the individual patient samples.

Using these hemoglobin pools our mean standard deviation for all pools prior to Jan. 1, 1966, was 0.52 and since that time is 0.49. For all practical purposes, therefore, the hemoglobins in this laboratory have shown a variability of 0.5 gm per 100 ml throughout the two years experience with the frozen pools. This represents a coefficient of variation of 3.0 to 5.0% for hemoglobin pools of 10.0 to 16.0 gm per 100 ml.

SUMMARY

The preparation and use of frozen hemoglobin solutions as a measure of reproducibility of the hemoglobin determination has been described and the data from our laboratory presented. This method has proved helpful in evaluating our hemoglobin procedure and has indicated that our reproducibility has remained relatively stable over a two-year period. Our reproducibility is well within the limits set by Sunderman and approaches that recommended by Page and Culver[4] for accurate cell indices.

Using serum as a diluent and storage at —30 C, the stability of these pools for a period of at least 18 months has been demonstrated.

It would appear that such pools would be equally helpful in any laboratory where storage at —30 C could be achieved since their use is not dependent on any specific methodology, mechanical equipment, or analysis by other laboratories. Used as described, however, standard deviations from various laboratories would be comparable.

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"Miscellaneous" Side Effects during Prolonged Phenothiazine Therapy

By THOMAS E. ZABORS, M.D., Milwaukee, Wisconsin

■ SIDE EFFECTS of the phenothiazine drugs have been conveniently classified under the following main headings:[1] *behavioral effects* (oversedation, restlessness, excitement, insomnia and toxic-confusional states); *central nervous system effects* (extrapyramidal syndromes, seizures, disturbed body temperature, and respiratory depression); *autonomic nervous system effects* (tachycardia, bradycardia, hypotensive crises, blurred vision, nasal conjestion, inhibition of ejaculation, fecal impaction, and aggravation of glaucoma); *allergic or toxic reactions* (cholestatic jaundice, agranulocytosis, purpura, hemolytic anemias, pancytopenia, dermatoses); *metabolic or endocrine effects* (weight gain, lactation, gynecomastia, menstrual irregularities, impotency in men, increased libido in women, false pregnancy tests); *miscellaneous effects* (unexpected deaths, electrocardiographic abnormalities, pigmentary retinopathy, melanin pigmentation, corneal and lens deposits). The "miscellaneous" effects will be reviewed in detail here.

UNEXPECTED DEATHS

Sudden, unexplained deaths occurring in patients on prolonged phenothiazine medication have received considerable attention recently. Postmortem examination usually shows little to explain the cause of death. Most patients are fairly young and ostensibly in good health. Usually, high doses of phenothiazines are being given although the duration of previous therapy may vary considerably. It cannot be said for certain that the deaths are due to the drugs. Some[1-3] have postulated that these deaths result from aspiration and asphyxiation during convulsive seizure, dystonic reactions, vasomotor collapse, massive inhibition of the brain stem, or ventricular tachyarrhythmias. Although chlorpromazine (Thorazine) was most often the drug administered to these patients, other phenothiazines have also been implicated such as prochlorperazine (Compazine), trifluoperazine (Stelazine), thioridazine (Mellaril), as well as the non-phenothiazine drug, reserpine (Reserpoid, Serpasil). Greiner[4] points out an interesting correlation between unexpected deaths in patients on prolonged chlorpromazine therapy and the presence in these patients of the "skin-eye" syndrome and of diffuse mellanosis of internal organs. Others[5] have described unique cardiac lesions in patients receiving tranquilizing medications who died suddenly and unexpectedly. There were focal areas of cardiac muscle destruction without polymorphonuclear leukocyte response and acid mucopolysaccharide was detected in the intramyocardial arterioles and arteriolar capillaries in areas of degenerating myocardial tissue. It has been hypothesized that these lesions might be due to the adrenergic blocking effects of phenothiazines. The patients' previously recorded ECG tracings gave no clear indication of the impending death.

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COMMENTS ON TREATMENT

Presented through the cooperation of the Department of Pharmacology, Marquette University, Milwaukee, and the Department of Medicine, University of Wisconsin, Madison

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ELECTROCARDIOGRAPHIC ABNORMALITIES

The significance of changes in the ECG associated with administration of phenothiazines is still unclear. The changes are often nonspecific. Kelly[6] reported on 28 psychotic patients who developed ECG changes while on thioridazine, two of whom died while receiving large doses of the drug. Thioridazine affected the ECG in doses as low as 200 mg. Its action was noted within 24 hours. The ECG changes were much like those due to quinidine or procaine amide (Pronestyl), consisting of T-wave flattening, notching or inversion, of ST-segment depression, and the occasional appearance of U waves. The terminal ECG patterns in both patients who died were those of heart block, alternating with periods of ventricular tachycardia. Other phenothiazines also affect the ECG in a similar manner.[7] The severity of ECG changes is no different in patients receiving phenothiazine drugs for several years than in those receiving them for several weeks. The apparent lack of progression of the ECG changes with time, the reversion to a normal pattern after cessation of the medication, and the reversibility of the changes by pharmacological methods suggests that the ECG changes are benign.[18] On the other hand, Richardson et al.[5] suggest that the frequently seen nonspecific ECG changes in patients receiving phenothiazine drugs might be an indication of a sensitivity on the part of these individuals to the drug.

PIGMENTARY RETINOPATHY

Toxic chorioretinopathy was first reported several years ago in patients receiving large doses of thioridazine for long periods of time. Characteristically, the course of this retinopathy is as follows: first, patients complain of decreased vision especially in subdued light, accompanied by sluggish pupillary reactions to light. With further impairment of vision, fine pigmentation can be detected in the fundus. At the same time pigment sheets develop with depigmented areas in between. There is no involvement of the vitreous, optic nerve or blood vessels.[8] No pigmentary retinopathy like that reported with thioridazine has been reported with patients on the dimethyl amine nor the piperazine types of phenothiazine derivatives although a few instances of nonspecific pigmentation and degeneration of the fundus have been reported in patients treated with these groups of drugs.[9,10]

MELANIN PIGMENTATION

In 1964 Greiner and Berry[11] drew attention to a new syndrome consisting of dermatologic and ophthalmologic changes in patients receiving prolonged and high doses of chlorpromazine. The skin changes were characterized by discoloration of the sun-exposed areas of the body, especially the face, neck, hands, and the exposed sclera, cornea, and conjunctiva. The abnormal pigmentation can range from a slight brownish darkening to a distinct slate-gray color, sometimes with a violet hue. Evidence is accumulating that the discoloration of the sun-exposed areas of skin in these patients is due to a melanin-plus-drug combination.[12-14] The pigmentation associated with prolonged chlorpromazine administration should be differentiated from other conditions in which melanin hyperpigmentation is prominent, such as Addison's disease, ochronosis, incontinencia pigmentis and Reihl's melanosis.[12] Various methods of treatment of the skin pigmentation have been tried including lowering the dosage of the drug involved, substitution of another phenothiazine, using reserpine instead of chlorpromazine, placing the patient in a darkened room and giving him dark glasses to wear for a period of four weeks, and finally, by administering a copper chelating agent such as D penicillamine (Cuprimine), 300 mg three times a day for six days, in order to block melanin production by inactivating tyrosinase. A mineral supplement should be substituted on the seventh day.[4]

CORNEAL AND LENS DEPOSITS

Fine, diffuse opacities in the posterior region of the cornea and stellate or cockleburr-shaped opacities in the anterior central part of the lens can occur independently of skin hyperpigmentation and are more common than skin findings in psychiatric patients receiving high doses of chlorpromazine over long periods of time (Figs. 1 and 2). Although chlorpromazine might be the drug most responsible for the lens and cornea opacities, other phenothiazine derivatives also appear capable of producing these changes.[15] Visual acuity does not seem to be impaired by the corneal or lenticular opacities, even though the deposits can range from clear to a dirty grey, or yellowish or

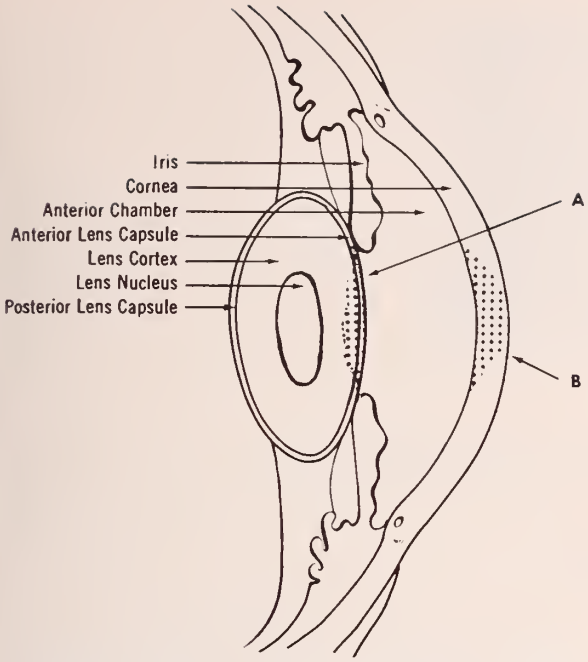

Fig. 1—Eye (saggital section) showing advanced changes in lens and cornea. A—dot-like particles in anterior capsular and subcapsular portion of lens are more discrete and opaque. They are white, yellow, or brown in color. B—white or yellowish-white dot-like particles chiefly in posterior half of the cornea, in the axial region.

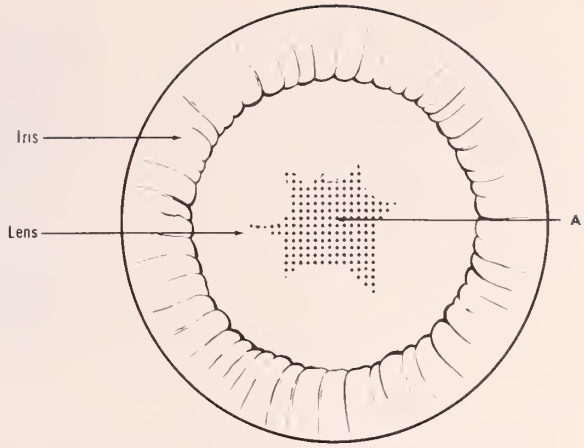

Fig. 2—Eye (anterior view) showing advanced changes in the lens. A—dot-like particles have assumed characteristic stellate pattern which, in severe cases, may be apparent with ophthalmoscope or, rarely, on gross examination (pupil dilated). In the most advanced cases, there is some visual impairment.

Figures 1 and 2 are reproduced from "Questions and Answers Regarding Dermatologic and Ophthalmologic Changes in Chronic Mental Patients on Prolonged, Substantial Dosages of Chlorpromazine and Other Phenothiazine Tranquilizers," 1966, with permission, through the courtesy of Smith, Kline & French Laboratories.

tan color. Barsa[15] has graded the apparent severity of cornea and lens changes during phenothiazine therapy and correlated them with the severity of skin hyperpigmentation. People with violet skin pigmentation developed more severe eye changes. In view of the high frequency (27%) of ocular opacities in patients receiving prolonged phenothiazine therapy, it is recommended that these patients be given ophthalmoscopic and slit lamp examinations at three to six month intervals. Since lower doses of phenothiazines do not seem to be associated with the occurrence of ocular opacities,[16] keeping the dose in the lowest therapeutic range seems indicated. Reduction of the abnormal ocular changes might become possible through the use of chelating agents.[17]

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THE PRESIDENT'S PAGE . . .

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Changing Medical Patterns and the Challenge

■ I RECENTLY ATTENDED two important medical conferences—the National Regional Medical Conference in Washington, D. C. and the Socio-economic Health Care Conference in Chicago. These were milestones in medicine because they were the first such conferences ever held in this country. The significance and importance of these meetings can only be projected for no one knows what the future will hold or what the end results of these very historic, cornerstone-laying meetings will produce for the practice of medicine. One only has to sit back and take a long-range look at the thinking and ultimate goals proffered in the papers presented by experts. This may give you the right perspective of the future practice of medicine, and in so doing you can attempt to guess what road organized medicine will be forced to follow because of hierarchy leadership and the gradual absorption of the inherent rights of the physician to practice medicine as he has known it or would like it to be in the future.

I can foresee in the not too distant future a complete change and the loss of individual physician rights. The direction of the practice of medicine is a determined pattern not to the liking of the private practitioner. This is an inevitable sequence and as certain as day will follow night this will be the course unless some concentrated effort is made to correct and change the present upcoming pattern as it is now formulated and assembled by the non-practicing physician and the non-medical people.

"Those things which one has become accustomed to for a long time, even though worse than things one is not accustomed to, usually gives less disturbance." (Hippocrates) The changing social and medical scene has become a source of great anxiety and despair to the thinking physician.

These changing patterns are due to many factors and actually can be termed intrusion! Medicare, trends in medical education with much emphasis on research, too much specialization, and the gradual indoctrination to present socialized thinking are all responsible to some degree. The third-party system and the ever-increasing involvement of hospitals and medical schools are affecting and regulating physicians in their practice of medicine. The impact of these developments in medical practice has been profound, and the emotional disturbance on the physician has been severe and very understandable. To date much of our energies have been dissipated in an attempt to prevent these changes. The positive therapy is solely dependent upon an accurate diagnosis.

The genesis of powerful primary forces for a change are now impinging upon us, and to prove this we only have to follow the threads of history. It is the technology of scientific medicine that has made this possible and we now control many factors which in the past have decimated the human race. The removal of nature's system of checks and balances has been instrumental in the plight that medicine has brought on itself and its present problems.

Health problems cannot be solved by legislation or by the introduction of new health programs. Health programs are actually people at work in the practice of medicine. To solve this dilemma we need more skilled people qualified by education and training. To increase health programs in the face of existing shortage of health manpower is unrealistic and irresponsible. The shortage is increased by the maldistribution of physicians. This gives rise to a "resentment to medicine," and is actually the foundation of many "forced medical programs" on physicians.

This has been my observation at both conferences and I am certain a new type of medical practice is developing fast and will be the pattern of the future. Medical schools, deans, and the forces of government all play an important role in this philosophy and are hard at work to help formulate this scheme. As I personally see it, the future practice of medicine will be confined to medical centers, university hospitals, and government establishments—all staffed by paid physicians. The patient will be transported to these institutions by every modern mode of conveyance, regardless of mileage. This system is actually in existence in some parts of our country today. This is practically the same pattern that exists in England today, after twenty years of national health service. The physician may see the patient at home or in his office, but treatment is done in an organized hospital center by another physician.

It is frightening to visualize this inroad on medical practice. It appears to spell the doom for the family physician. Some of the deans and leaders of this way of thinking feel that all patients belong in a hospital under specialized care, and there is no longer room for the practitioner in the field. I am certain this philosophy will grow under well conceived programs sponsored by a third party.

I am not certain what the answer is to this problem, but I am certain that it is not the type of practice we want, but the forces are potent and strong. I believe we need strong leadership on the local and national level now! I feel that the only key that we have to this problem is to rise up and voice our opinions loud and strong to our patients. Physicians must take a more vigorous part in politics at all levels.

Y. E. Drew M.D.

EMERGENCY CALL SERVICE
If you have it, let the people know. If you don't have it, should you?

The Commission on Public Relations and Communications, under the chairmanship of Dr. Joseph S. Devitt of Milwaukee, has been developing a program whereby the public can be better informed on an emergency call system which many communities now have and which others are contemplating.

A vital indication of medicine's concern for the public good is the existence of an emergency call service in every community large enough to warrant one. Where such service exists, it is equally important that the people of the community know it, and know how to use it. As with most other public health messages, this may require frequent repetition.

There are many methods of keeping this information before the community. The Commission has contacted all county medical society presidents and secretaries to offer them suggestions and help in caring out this informational program. The cooperation of local news media is being sought.

The Public Information Department of the State Medical Society is available to assist any county medical society in the preparation of such information.

If a community does not have an emergency call system, what should someone do in the community to get a doctor in a hurry? This, too, can be important information which should be explained to the community. And, perhaps, it is something for county medical societies to consider: is it time to start such a service?

BROCHURE: PLASTIC SURGERY

As a service to the medical profession and the public, the American Academy of Facial Plastic and Reconstructive Surgery, Inc., has developed a brochure, "Plastic Surgery." The brochure corrects several false impressions and answers many common questions about plastic surgery. Copies are available from Jack R. Anderson, M.D., Secretary, 322 California Company Building, 1111 Tulane Ave., New Orleans, La. 70112.

* * *

IN EIGHT YEARS there has been a dramatic rise of 42 percent in the number of veterans hospitalized for hardening of the arteries of the heart—most common cause of death in the United States—the Veterans Administration reports.

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EDITORIALS

D. N. GOLDSTEIN, M. D., *Editorial Director*

Service Above Self

■ WISCONSIN HAS GOOD reason to be proud of the distinguished doctors who have participated in the American Medical Association's project of Volunteer Physicians for Vietnam. Elsewhere in this issue Dr. Victor S. Falk, Jr., of Edgerton, describes his experience in a gripping narrative of medical practice under the most primitive conditions. Dr. Reynold M. Nesemann of Kewaunee, Dr. William Gallagher of La Crosse, Dr. Joseph Springer of Durand, Dr. Charles Hopkins of Madison, and, most recently Dr. Samuel Harper of Madison and Dr. Thomas P. Chisholm of Arcadia, can undoubtedly endorse and add to this expression of high-minded concern for the alleviation of human misery.

At the request of the U. S. Department of State, the AMA assumed responsibility for the administration of the program last summer. Physicians who volunteer for the program serve the civilian population for a minimum of two months, receiving for their services a $10-a-day living allowance, transportation, but no salary. Because of the limited facilities, the Vietnamese government permits only 32 volunteer physicians in the country at any one time; the AMA encourages many more to volunteer so that the full contingent is maintained at all times.

Working under conditions of unbelievable hardship, the volunteer physicians have brought only a token measure of aid to a vast population innocently caught in what has been described as the most barbarous war in history. Elderly people, women and children, already disease ridden and impoverished, have had added to their misery the misfortunes resulting from military action. But that token measure is significant in an area where skepticism as to American purpose is natural.

While the doctors who volunteered for Vietnam acted on the loftiest principles of charity and self-sacrifice, they did so also as representatives of the American people who have given of their flesh and blood as well as their substance and property to improve the lot of the less fortunate people of the world. As a nation we are unique in history in the congruity of official policy with private sentiment to make available the good things of our society for the relief of the down-trodden, the oppressed, the poor, the humble and those whose habitat is in the dark misery of the world.

Another of the humane projects bringing the benefits of medical science to the deprived areas of the world is the People-to-People Health Foundation's hospital ship, the S. S. HOPE, and its land-based, related projects. In its five completed voyages, each lasting about a year, over 1000 volunteers have served on the ship, including 487 physicians from 244 cities and towns in 40 states. Among them were Dr. Joseph P. Springer of Durand, Dr. William B. Gallagher of La Crosse, Dr. J. S. Vedder of Marshfield, and Dr. Alfred Jerofke of Milwaukee.

The saga of the continuing voyages of the HOPE represents a bright phase of American humanity, for in addition to simple relief of suffering, the HOPE project serves an educational mission and a seeding function in the under-developed countries it visits. Cooperation with local schools of medicine, medical societies, and individual physicians produces a long-range result which continues after American direct participation is ended. Again, it is the individual American physician, motivated by high altruism, who supplies the dynamic of the program.

It is to be hoped that more Wisconsin physicians will find it possible to participate in these fine volunteer projects. Besides the rewards of personal satisfaction that come from doing what one says he believes, the doctors who have volunteered for Vietnam or for the S. S. HOPE have earned the applause of the entire community.—D.N.G.

THEY DESERVE OUR RESPECT

. . . reprinted with permission from the *Phillips* Bee, Dec. 8, 1966

IN RECENT YEARS a large segment of our affluent population has become increasingly critical of our doctors—in fact some of this criticism has reached such alarming proportions that the dignity and pride, which has always been a part of the medical profession, is beginning to ebb.

If you think the above is an overstatement, just think back to some of your recent conversations with those around you and you will recall comments such as: "Physicians are unscrupulous, indifferent to our ills and they are greedy," or "Back in the good old days, doctors weren't too busy to make house calls," or "Doctors make too much money for the few services they perform," or "They all charge too much for what little time they spend with their patients."

The list could go on and on and we think that citizens who advance such statements are being grossly unjust to a professional group which, by and large, contributes more to humanity than any other profession.

Let's take a brief look into the life of a physician: Conscientious doctors have no home life, as most of us desire, and as most of us already have! While we sleep, work regular hours and find plenty of time for recreation, they are busy holding office hours, making hospital calls—and quite frequently they are called from their beds at all hours of the night! In addition their real work constitutes that from which most of us would rapidly flee—helping the sick, mending smelly, bleeding and broken bodies and glimpsing a person's very soul when he is at his worst.

Another thing that most persons forget is the fact that they see the doctor only when they are sick and that he is soon forgotten when health has been restored.

Most citizens pay more attention to keeping their automobile, their TV sets and their plumbing facilities in tip-top condition than they do in maintaining their bodies. The same persons who gripe the longest when a doctor asks that sick children be brought to his office rather than make a house call, will gladly pay exhorbitant fees to have a plumber or a TV repairman rush over to their home. Even when it becomes necessary for a doctor to make a house call, his extra fee for such a call is nearly always less than that charged by a plumber or a TV repairman.

Research laboratories have turned out hundreds of miracle drugs to prolong our days upon this earth—now all we need to make it complete is to have some research chemist discover a pill to make doctors immune to unwarranted criticism.

Better yet, let's quit carping about the doctors whom we see only when we are desperately ill, and regard them with the respect which they have earned through selfless dedication and hard work.

SPECIAL TO THE JOURNAL

SIXTY DAYS IN VIETNAM

By VICTOR S. FALK, M.D.

Edgerton, Wisconsin

An American physician faces challenges in Vietnam that most United States doctors see only in textbooks. This was the experience of the author, who as a small community doctor, had the desire to break daily routine and the comforts of home in order to revitalize and enhance his knowledge of medicine and people for the benefit of his patients at home, for the health of the Vietnamese people, for the dignity of his profession, and for himself. A rewarding experience which will be reflected in his daily activities throughout life.

■ IN 1965 it became apparent that the United States would need to augment medical care for the civilian population of the Republic of Vietnam. There were, perhaps, one thousand physicians in the country but about 70% of these were in the military. The State Department's Agency for International Development, in cooperation with the People-to-People Health Foundation, sent 119 United States physicians to Vietnam during the first year of "Project Vietnam." In July 1966 the American Medical Association took over the program, still in conjunction with the State Department, and agreed to supply twenty-four to thirty-two physicians at all times for service in the provincial civilian hospitals. The tour of duty for each volunteer physician is usually sixty days.

The first Wisconsin physician to go to Vietnam was Dr. Reynold M. Nesemann of Kewaunee, who left on Aug. 2, 1966. He was followed a month later by Dr. William Gallagher of La Crosse. In late September, Dr. Joseph Springer of Durand, Dr. Charles Hopkins of Madison, and I went out with a group of fourteen physicians. This was the largest single group to leave at one time and included three physicians who were going back for their second tour of duty. We also were accompanied by Bernard Marquardt, a senior student from the University of Wisconsin Medical School, who served his preceptorship in Vietnam. Dr. Samuel B. Harper of Madison and Dr. Thomas P. Chisholm of Arcadia went out in early December. Prior to this program two Wisconsin physicians went to Vietnam in 1960 for Orthopedics Overseas. They were Drs. Albert Freedman of Green Bay and John Van Driest of Sheboygan.

During our briefing in Saigon we were told that there were three reasons for our being there. The first was for the psychological impact, both on the Vietnamese and on the home front. The second was to teach and train the Vietnamese in the provincial hospitals to which we were assigned. Although there was very little time for didactic teaching, perhaps some of our methods and practices rubbed off on our observers. The third function was immediate medical care. The last proved to be the most important and consumed most of our time.

. . . Our group before we departed for Vietnam is shown here with Dr. Charles H. Moseley (center), director of the AMA Department of Governmental Services. Dr. Joseph P. Springer of Durand and myself are on the left and Bernard L. Marquardt, a medical student at the University of Wisconsin, and Dr. Charles E. Hopkins of Madison are on the right of Dr. Moseley.

FEW CHANGES IN 70-YEAR-OLD HOSPITAL

I was assigned to the province hospital in Vinh Binh in the Mekong Delta. The hospital had been built over seventy years ago by the French and aside from the addition of a small surgical suite, I am sure there had been very few changes in the interim. Except for the surgery there were very few doors, windows, or screens throughout the hospital. The hospital was listed as having three hundred beds, but since there were frequently two or three

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Doctor Falk, who is Medical Editor of the WISCONSIN MEDICAL JOURNAL, is a general surgeon at Edgerton where he is also chief of staff of Edgerton Memorial Community Hospital. A 1939 graduate of the University of Wisconsin Medical School, Doctor Falk was a flight surgeon in the Medical Corps, U. S. Navy, from 1941–1947. He was awarded the Silver Star medal by the Marines at Guadalcanal for "gallantry in action" in 1942. He also received two commendations by Marines for "excellent service" in the Pacific in 1945. Since leaving the service, he has continued his practice in Edgerton. For many years he was the City Health Officer. He is a past president of the Rock County Medical Society. In addition to being a member of the State Medical Society of Wisconsin and the American Medical Association, he also is a member of the Wisconsin Surgical Society and the American Medical Writers Association. He has traveled widely, attending medical meetings throughout the world and the United States.

Photos taken in Vietnam by Armand Noble of the *Milwaukee Journal.*

. . . Two single beds pushed together could accommodate five patients. Hospital charts were interesting for both their brevity and language.

patients to a bed, this figure was not significant. The beds consisted of boards covered with a thin straw mat. There were no mattresses, sheets or blankets, but this really simplified sanitation. Two single beds pushed together could accommodate five patients. Crowding did not seem to trouble the occupants and at times the relatives joined them in bed during the siesta. Frequently, there were infants in the beds along with the adults, either because they had been brought along with their breast-feeding mothers, or had been delivered by Cesarean section and were kept in the surgical ward. Since the surgical ward was the only one in the hospital that had facilities for dressing changes, patients with severe dermatological conditions and with scrofula would share beds with recent casualties and surgical patients. At one time I had forty-nine patients in a twenty-one bed female surgical ward.

My first day at the hospital left me feeling inadequate, frustrated, and somewhat nauseated. There were maggots in the dressings and ants in casts, old dressings were thrown on the floor, a dog accompanied me on my first rounds, and I found myself wishing that a Navy Seabee outfit would bulldoze the hospital off the face of the earth. (After the first day, these things never occurred again.) However, there were fresh casualties the first afternoon and I felt much more at home in surgery.

SIESTA TIME MANDATORY

One of the major causes of frustration was the inviolable two-and-a-half hour siesta every noon. If we worked into the noon hour the siesta was prolonged at the other end. If a casualty had the misfortune to come in during this time, he was placed in the receiving room (this was also used as the recovery room) to await the end of the siesta, should he survive. During this time the nurses all went home and the hospital charts were locked up. Another frustration was our having to leave the hospital at dusk as it was not considered secure after that time. During the year two Vietnamese nurses had been kidnapped at night and had never returned. There was always a shortage of something. The Vietnamese nurse anesthetist was skillful and intubated all patients while using sodium pentothal, ether, and oyygen. However, there was one period of over two weeks when there was no oxygen at the hospital and for anesthesia he used an old French ether bell attached to a pig bladder. This seemed to produce a high degree of asphyxia but very little relaxation. For another period of time there was no morphine, Demerol, codeine, or even an APC. However, we did find a supply of old French Pantopon to tide us over. At other times there were shortages of x-ray films or 4 x 4 dressings or tetanus antitoxin. The one large operating room light burned out and there was no bulb for replacement during my time there. On another occasion the only autoclave in the hospital went out of commission. Sponge counts were never made in surgery.

The hospital consisted of ten large wards where the patients apparently paid nothing, and of several small four-bed "private wards" where the charge was about eighty cents a day. Running water was limited to surgery, x-ray, and the laboratory. This water was so contaminated that it was necessary to rinse off with an antiseptic at the conclusion of

scrubbing prior to surgery. Water for the wards was drawn from a cistern in buckets and kept in a large stone crock in each ward. Electricity was likewise available only in surgery, x-ray, and the laboratory; and for one-half day each week, there was no electricity in the entire city. Very soon the United States military will install a generator for the exclusive use of the hospital. A pure water supply is also planned and will be the first one in the entire province.

LABORATORY FACILITIES LIMITED

Laboratory facilities were limited and for one period of two weeks while the laboratory technician was on vacation, no laboratory work could be done at all except for blood-typing in surgery. Blood cross-matching was never carried out and blood for transfusion was difficult to procure. The Vietnamese were reluctant to give blood even to their own relatives and indeed, most of them were so anemic, that they had little blood to spare. Hematocrits of 25 were quite common in preoperative patients. When donors were available, frequently 250 cc's of blood was all that could be taken. The widespread anemia was probably on the basis of inadequate nutrition and intestinal parasites. Frequently American nurses, doctors, or military personnel would give blood in emergencies. During the same two-week period when there were no laboratory facilities, the x-ray technician was also on vacation. This complicated the treatment of numerous fractures and foreign bodies. The x-ray unit, which was completely unshielded, was located in a building remote from the rest of the hospital. This necessitated carrying the patients to x-ray on stretchers. This was usually accomplished by the patient's relatives who would return with the patient and the wet films. Once a patient was placed in traction, there was no way to get another x-ray film until the fracture was considered secure enough to be taken down and the patient again transported to x-ray. The only pathologist was in Saigon, and no pathology reports were returned in two months.

. . . Severe perineal injuries resulted from mine explosions with the loss of extensive tissue. Countless gunshot wounds of the abdomen were explored and perforations were encountered.

Since there were only three Vietnamese physicians in Vinh Binh to care for the population of 550,000 in an area of over 1100 square miles, the need for outside help was obvious, even if there were not a war going on. Doctor Nguyèn-Huy-Hùng, the "médecin chef," was the hospital administrator, did all of the emergency surgery at night, and was responsible for the health and medical care of the entire province.

LIFE EXPECTANCY 35 YEARS

Life expectancy in Vietnam is thirty-five years. About half the children die before the age of five and approximately eight per cent of the infants die in the first week.

There was a huge backlog of surgical conditions waiting to be taken care of whenever there was a lull in the casualties. The number of harelips in south Vietnam seemed unusually great but perhaps it was because there were three generations of people with this congenital defect that had never been repaired. Several of these plastic procedures were carried out every week and this was probably the finest public relations gesture in the medical field. Far-advanced malignancies were prevalent and many of them were inoperable by the time the patients appeared at the hospital. Large ovarian cysts were quite common and large nontoxic goiters were also numerous, probably much like the situation here in the goiter belt a generation ago. Tuberculosis was widespread and many patients were seen with scrofula and Pott's disease.

Several patients who had sustained extensive human bites were admitted to the hospital and one unfortunate nursing mother had a painful experience when bitten on the breast by a pig when she was assisting at the delivery of piglets. Goring by water buffaloes was another cause of injury. Since river bathing was common practice, patients were found with leeches in the vagina, which resulted in rather profuse bleeding. Malaria, cholera, plague, typhoid, and typhus were all quite common and some leprosy was also encountered. On my first day at the hospital I saw four patients with tetanus, all of whom survived. The youngest of these was a fifteen-day-old baby and the diagnosis was made by the parents before the infant was brought to the hospital. Treatment consisted of much smaller doses of tetanus antitoxin than ordinarily used in this country. All of the casualties were immediately given 1500 units of tetanus antitoxin upon admission to the hospital. Preliminary skin testing was never done. Only one case of tetanus developed in a patient who had received that dose of tetanus antitoxin during my stay there. The other tetanus cases usually had minor injuries and had been untreated prior to developing their lockjaw.

. . . Adjacent to our hospital was a Catholic orphanage. It was unusual because of the many newborn infants.

CIVILIAN CASUALTIES MAIN CONCERN

Most of our work, however, was in caring for the civilian casualties. In one month I encountered more casualties than I had in all of World War II. These ranged in age from a breast-feeding infant of one year with a hand blown off to a 96-year-old woman who had sustained a bullet wound of the scalp. The wounds resulted from gunshots, grenades, mines, booby-traps, and air strikes. Mangling injuries of the hands and feet and amputations were all too common. Compound fractures of the femur were frequently encountered and treated with skeletal traction. Elective orthopedic surgery was held to a minimum because of the prevalence of infection.

Undoubtedly the most pathetic situation I encountered was a ten-year-old girl who required a forequarter amputation because her shoulder had been shot away. Severe perineal injuries resulted from mine explosions with the loss of extensive tissue. These were treated initially by colostomy and it is a matter of conjecture as to what the ultimate treatment will be or where it will be carried out. Countless gunshot wounds of the abdomen were explored and perforations were encountered in the liver, spleen, stomach, large and small intestine, uterus, tubes and ovaries. Because of the prevalence of intestinal parasites, large numbers of Ascaris were often seen free in the abdomen where there had been bowel perforations. Chest wounds were also quite common. Most of these were treated with a simple, disposable plastic tube and a Heimlich valve. The response to this type of tube drainage was often dramatic. Many skin grafts were carried out on old wounds. I found that a simple pinch graft was usually satisfactory, especially since the dermatome at the hospital could not be calibrated. Operating times were usually rapid because of the absence of adipose tissue.

The deliveries in the country were attended by mid-wives. When there was difficulty, the mid-wives brought their patients to surgery. This was no particular problem in the maternity hospital adjacent to us, but was a real hardship for the patients out in the province. Cesarean section was carried out quite frequently because so many of the women were small and also because so many developed complications in grand multiparity. An unusual number of shoulder presentations were encountered. Two patients having ruptured uteri were seen in the two-month period. However, only one patient with appendicitis was seen during that same two-month period. One rather unusual Cesarean section was performed on an achondroplastic dwarf. Complete uterine prolapse was also a common condition.

HOSPITAL CHARTS INTERESTING

The hospital charts were interesting for both their brevity and language. A typical report of history and physical exam would be "gunshot wound (abbreviated to gsw) abdomen." The operative record would simply state "laparotomy with repair of whatever number of perforations of the bowel." The notes would frequently be written in three languages, French, Vietnamese, and English. Some of the older male nurses could speak some French and English, but for the most part an interpreter was necessary to communicate with the patients. The chief operating room nurse was an outstanding man who could pinch hit for the anesthetist, could do amputations and suturing, and I am sure, was capable of performing most types of surgery.

Many of the casualties had been wounded twenty-four to forty-eight hours prior to admission to the hospital. Transportation of the patients was accomplished by sampans, pedicabs, Lambrettas, a net or hammock slung across a bus, occasionally by helicopter or ambulance, and often on foot. Since transportation back to the outlying districts was difficult, the patient's hospital stay was often prolonged for dressings or convalescence.

Frequently our patients would have been subjected to Chinese or Cambodian medicine before we would see them. The Chinese medicine consisted mainly in application of large suction cups over the affected area. This would leave a large obvious disc of counterirritation. I have pictures of two of our

. . . In retrospect, I found the Vietnamese people warm, friendly, and appreciative and I became very much attached to them.

nurses who were treated by this method, one with a large mark on his forehead seeking relief from a headache and the other nurse with numerous large marks on his back, where he had been treated for a chest cold. The Cambodian medicine was much more drastic and apparently consisted of a caustic paste. I saw the result of this where it had been applied to a child to such a depth that the styloid process of the mastoid bone was visible in the wound. In another patient the skin of the dorsum of the foot was deeply sloughed off and required subsequent grafting. The patients with goiters were all superficially scarred by tentative nicks and caustic burns.

ORPHANAGE ADJACENT TO HOSPITAL

Adjacent to our hospital was a Catholic orphanage. It was unusual because of the many newborn infants. Since there is no fresh milk in the country, it is necessary to procure canned milk and this also is in short supply. The Vietnamese Sisters of St. Paul also have a school for six hundred pupils, do the cooking and laundering for the hospital, and to raise money, do laundry for the American military.

In addition to the two American volunteer physicians assigned to the Vinh Binh hospital, there was also a small Air Force Military Assistance Team. This consisted of two young doctors who had recently completed internships and eight enlisted men. There were many of these military assistance teams (Army, Navy, or Air Force) throughout the country in other province hospitals as well. There were also volunteer civilian teams from other free countries such as Australia, the Philippines, and Switzerland.

Another aspect which is extremely important but one in which I didn't have much time to participate is that of rural visits. The only one that I made was by helicopter to a small island where there had never been a doctor before. Within a few minutes almost four hundred people appeared, wanting to be seen. This, too, is a great public relations program and is an effective method of really getting to the people.

Rapport with the American military was excellent, and we appreciated the opportunity of attending military briefing with the Advisory Team every evening.

REWARDING AND GRATIFYING EXPERIENCE

In retrospect, I found the Vietnamese people warm, friendly, and appreciative and I became very much attached to them. Despite some of the frustrations and shortages, I would regard my experience as rewarding and gratifying and one which I simply would not have missed. In comparing experiences with other doctors who had been out earlier, definite progress in medical care has been accomplished. Surely we are committed both medically and militarily in Vietnam. Abandonment now would result in an incredible slaughter.

. . . The hospital.

. . . A supply room.

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Congenital Absence of the Gallbladder and Cystic Duct

By JOSEPH E. GUTIERREZ, M.D., CHARLES MARKS, M.D., and STUART D. WILSON, M.D., Milwaukee, Wisconsin

■ ALTHOUGH OPERATIONS on the biliary tract are among the most common surgical procedures carried out, it is rare to discover absence of the gallbladder and cystic duct at laparotomy. An accurate clinical diagnosis of gallbladder agenesis is impossible to make preoperatively. Diagnosis has not been made in the 150 cases so far recorded in the world literature[1,2] because of the inherent difficulty in distinguishing with certainty between a nonfunctioning gallbladder and an absent one.

Our recent experience with a patient in whom the gallbladder and cystic duct were congenitally absent provides us with an opportunity to review some of the more interesting aspects of this problem.

INCIDENCE

The rarity of congenital absence of the gallbladder and cystic duct is attested to by the fact that less than 150 cases have been recorded in the world literature, and that of this total, less than 100 were discovered at the time of laparotomy, the others reflecting a fortuitous finding at autopsy.

A review of the world literature by Latimer et al[3] indicated that up to 1947 a total of 71 cases had been recorded, and further study of the literature by the present writers indicates that 10 other cases had been recorded up to that time, bringing the total to 81 cases of agenesis of the gallbladder and cystic duct. By 1961, Gerwig et al[4] had added 61 cases, while in the past four years a handful of cases has further been documented in the world literature.[5–7]

The incidence of gallbladder and cystic duct agenesis lies within a range of .03% to 75%.[3] The average age at which this is normally discovered is 46 to 50 years. Although in all autopsy studies there has been an equal sex incidence, at the clinical level, females have been more frequently encountered with this anomaly than males, and it is significant that the symptoms occurring in these patients with absence of the gallbladder very closely resemble the symptoms of gallbladder disease. Although nausea, fatty food intolerance, bloating and flatulence do occur, the commonest symptoms have been found to be upper abdominal pain and jaundice.

In the cases reviewed by Latimer and his associates,[3] 76% of patients had suffered upper abdominal pain, while one-half of all the patients studied had suffered an episode of jaundice. The cases reviewed by Gerwig et al[4] demonstrated that 89% of the patients had complained of upper abdominal pain and 55% had had at least one episode of jaundice. In an appreciable number of patients, pain and jaundice may occur concomitantly, and it was noted that the intensity and location of the pain was more variable in the cases of absence of the gall-

From the Marquette University School of Medicine and Milwaukee County General Hospital.

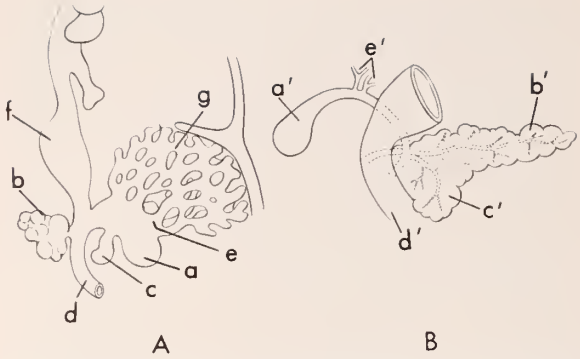

Fig. 1—The development of the gallbladder and pancreas. In the fifth week of intrauterine life, the hepatic bud (g) develops, and from it are produced the gallbladder (a, a'), the intrahepatic (e) and extrahepatic ducts (e'), as well as the ventral pancreas (c, c'). Also shown are the primitive foregut (f), duodenum (d, d'), and dorsal pancreas (b, b').

bladder than in those with cholecystic disease. In 26% to 43% of the cases, calculi were found in the common duct and provided the explanation for jaundice. It is important to note that many patients with common duct calculi had been asymptomatic.

DEVELOPMENT OF THE GALLBLADDER AND EXTRAHEPATIC BILIARY PASSAGES

In the fourth to fifth week of intrauterine life, the 4 mm human embryo develops an entodermal bud which extends from the distal end of the foregut into its ventral mesentery, thereby providing the hepatic bud whose branching stems will produce the liver with its intra- and extrahepatic duct system including the gallbladder.

The site of the future duodenal ampulla and ostium of the common bile duct and main pancreatic ducts are determined by site of sprouting of this hepatic bud and as it grows upwards embedded in the ventral mesentery, it penetrates the septum transversum in the interior of which its terminal branches produce many rods of cells which undergo recannulization to become the intrahepatic biliary ducts and canaliculi. From the base of the bud, close to the intestine, two secondary buds arise to provide the ventral pancreatic buds which quickly degenerate in man and disappear. The right bud grows rapidly to produce the lower part of the head of the pancreas and terminal portion of the main pancreatic duct and opens into the duodenum where it is closely associated with the opening of the common bile duct at the duodenal papilla.

At this time the main hepatic stem continues to lengthen and on its right side there develops a branch which without further division ends in a blind diverticulum which is destined to become the future gallbladder, the communicating branch becoming the cystic duct. Failure of development of this branch will result in agenesis of the gallbladder and cystic duct. It is surprising that this anomaly is as infrequent as reports would indicate in the light of this developmental history (Fig 1).

CASE REPORT

A 34-year-old white man was admitted to the hospital on Nov. 15, 1964, complaining of right upper quadrant abdominal pain accompanied by postprandial belching, flatulence and occasional episodes of nausea.

His history indicated that he had suffered from nervousness and that in 1962 he had been hospitalized at a Veterans Administration hospital with palpitation, and that after thorough evaluation he had been transferred to the psychiatric unit for shock therapy and subsequent medication with tranquilizers. In July 1964, he was again hospitalized at the neuropsychiatric unit of the VA hospital, and at that time he complained of severe right upper quadrant discomfort which was related to ingestion of food. Cholecystography was carried out and failure to visualize the gallbladder was considered to be significant. In September 1964, this patient was first seen at the Outpatient Department of our hospital with similar complaints, and two separately performed cholecystographic examinations using a double dose of contrast material for the second examination again resulted in failure to visualize the gallbladder.

The patient was admitted for elective cholecystectomy. At this time, a thorough investigation demonstrated no previous history of jaundice or any other significant gastrointestinal symptoms beyond those enumerated.

Clinical examination demonstrated a well-built, well-developed, healthy looking male in no apparent distress with no relevant abnormalities in any systems. Another double dose cholecystogram failed to visualize the gallbladder, while upper gastrointestinal x-ray series and barium enema examinations were normal. At laparotomy it was noted that the gallbladder was absent and that there was no gallbladder bed, nor could any cystic duct be dissected out, nor was there any evidence of the gallbladder on the left side. The common duct from the junction of right and left hepatic ducts down to the pancreas was exposed and was seen to be completely normal in appearance and caliber. Common duct exploration was carried out. No calculi were found in the duct. A No. 5 Bakes Dilator could readily be passed through the ampulla into the duodenum and a T-tube was placed in the duct. A cholangiogram

Fig. 2—Operative cholangiogram confirms congenital absence of gallbladder and cystic duct.

was performed and failed to demonstrate either a cystic duct or gallbladder (Fig 2).

The patient had an uneventful postoperative course, the T-tube being withdrawn on the tenth postoperative day. The common duct pressure just prior to removal of the T-tube was 19 cm of bile. Follow-up examination as an outpatient showed total recovery from the effects of surgery, nor did he have any further complaints attributable to his gastrointestinal tract.

MANAGEMENT

As there is no method clinically to differentiate between the diseased gallbladder which fails to visualize and an absent one, the diagnosis obviously can only be made with certainty at laparotomy. Exploration of the common duct and operative cholangiography is necessary to demonstrate not only the absence of the gallbladder but also to prove that there is no intrahepatic ectopic gallbladder.

The course of action in this case would seem to be the desirable one in such a situation—choledochotomy to ascertain the absence of common duct calculi and a patent sphincter of Oddi followed by T-tube cholangiography to demonstrate that the gallbladder in effect is not intrahepatic. It is notable that despite the absence of a gallbladder, the intraductal pressure remains within normal limits.

SUMMARY

A patient with congenital absence of the gallbladder and cystic duct is reported. The subject is briefly reviewed. Symptomatology and nonvisualization of the gallbladder results in a preoperative diagnosis of cholecystitis. The diagnosis of congenital absence of the gallbladder is made at the time of laparotomy. Choledochotomy and cholangiography is mandatory to rule out an intrahepatic gallbladder and/or common duct stones.

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* * *

Clinical Center Study in the Treatment of Patients with Diseases of the Endocrine Glands

The cooperation of physicians is requested in the referral of patients for a study being conducted by the Endocrinology Branch of the National Cancer Institute at the Clinical Center, National Institutes of Health, Bethesda, Md. Methods have been developed for measuring plasma androgens and gonadotropins and estrogens. These hormones are being studied in patients with breast cancer, hypogonadism, pituitary tumors, and virilization.

Patients with early metastatic breast cancer are needed for study and treatment. Patients with diseases of the gonads or pituitary will be accepted for diagnosis and initiation of therapy.

Physicians interested in having their patients considered for admission to this study may write or telephone: Mortimer B. Lipsett, M.D. or Griff T. Ross, M.D., Clinical Center, Room 12-N-204, National Institutes of Health, Bethesda, Md. 20014; Telephone: 656–4000, Ext. 62021 (Area Code 301).

Postoperative Chylothorax: A Second Look

By URIEL R. LIMJOCO, M.D. and VINCENT L. GOTT, M.D.
Madison, Wisconsin

■ ALTHOUGH TRAUMATIC chylothorax has occurred after nearly every intrathoracic operation,[1] it is still an uncommon complication following surgery on the great vessels of the chest. It is a problem that will occur in any large series of thoracic vessel procedures and a problem that can be most difficult in its solution.

ANATOMY OF THE THORACIC DUCT

The thoracic duct typically enters the chest through the aortic hiatus of the diaphragm between the azygos vein and aorta, slightly to the right of the vertebral column.[2] It ascends in the posterior mediastinum and begins to cross obliquely to the left at the level of the seventh thoracic vertebra. It passes the thoracic inlet, arches 3 to 5 cm above the clavicle and drains into or within 1 cm of the angle formed by the junction of the left jugular and subclavian veins anterior to the left subclavian artery.[3–5] Variations are more common in the upper part of the thoracic duct, especially in its termination, than in its lower part.[6] Accessory lymph channels and lymphaticovenous communications with the azygos vein have been found throughout the entire course of the thoracic duct.[7–9] Mobilization of the left subclavian artery consequent to thoracic vascular procedures could result in injury to the main duct or its accessory channels.

INCIDENCE

With the increase in number of thoracic cardiovascular procedures in recent years there has been a sharp rise in the incidence of postoperative chylothorax.[10] In 1956 Maloney and Spencer[11] collected 13 cases in 2,660 thoracic cardiovascular procedures. Steiger, Weinberg and Fell,[4] in 1960, reported 6 cases in 1,000 thoracic cardiovascular operations. In both reports the incidence was about 0.5%. Operative records at the University of Wisconsin Hospitals (1940–1964) were reviewed; and in 545 operations on the great vessels of the chest, 3 cases of postoperative chylothorax were reported as follows:

Operation	*Number*	*Postoperative chylothorax*
Blalock procedures	98	1
Ligation of patent ductus arteriosus	285	1
Repair of coarctation	128	1
Miscellaneous procedures on the great vessels	34	0
Total	545	3

Incidence: 0.55%

Three other cases of chylothorax are recorded at the University of Wisconsin Hospitals but these were associated with mediastinal tumors (lymphosarcomas) and not related to any cardiovascular procedure. The incidence of postoperative chylothorax in our series is therefore about the same as that reported by other investigators.

DIAGNOSIS

Although the diagnosis of postoperative chylothorax is not difficult, injury to the duct system at the time of thoracotomy is generally unrecognized because of decompression of the lymphatic system from preoperative fasting.[12] Persistence of postoperative hydrothorax, the character of the chest tube drainage or chest aspirate, and absence of systemic manifestations are the main considerations for diagnosis. In patients receiving oral feedings the intake of fatty

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foods will give the drainage material its milky appearance. Lymphangiography has been described both for diagnosis and localization of injury.[13] In a recent publication Chavez and Conn[14] utilized lymphangiography not only for diagnosis and localization but also for determining the form of therapy based on existing collaterals that were demonstrated. The average interval between surgery and diagnosis is 7 days and between diagnosis and surgical management of chylothorax 19 days.[10] All three cases in our series were diagnosed on the fifth postoperative day.

MANAGEMENT

The treatment for postoperative chylothorax is divided into conservative and operative. It is usually wise to give patients a three-week trial with repeated thoracentesis or closed tube drainage before exploratory thoracotomy is undertaken.[11] Chyle, being less irritative to the tissues than blood, may produce reactions not pronounced enough to favorably seal the ductal rent. This, together with the negativity of intrathoracic pressure and the effect of the abdominal respiratory pump, tends to maintain leakage of chyle.[15] It is therefore important that particular attention be given to the following points in the conservative treatment of postoperative chylothorax:

(1) Minimize formation of chyle. Food and fluid administration should be withheld by mouth and nasogastric suction instituted.[2] The resulting decrease in peristaltic activity will also diminish lymph flow.[16] Since chyle has the electrolyte concentration approximating that of serum and a protein concentration of about 1 to 6 gm per 100 ml,[16–17] adequate replacement should be given by vein.

(2) Maintain pulmonary expansion. This is done by repeated thoracentesis, closed chest suction, or water seal drainage. These procedures bring about a better pulmonary function and somehow aid in promoting adhesions that may seal up leaking lymph channels. Infection is usually not a problem. Lampson[18] documented the bacteriostatic properties of chyle when cultures of *Escherichia coli* and *Staphylococcus aureus* failed to multiply in pure chyle.

(3) Minimize the flow of chyle. Special effort should be made to diminish laughing, coughing, and straining. Only an absolute minimum of physical activity should be allowed to minimize lymph flow from the extremities. Even positioning should be such that the patient's head is slightly elevated.[2] Subcutaneous fluid administration should be avoided to prevent subcutaneous lymphatic flow.

Since chylothorax from surgical trauma results usually from a localized disruption in duct continuity rather than from extravasation in a duct with multiple areas of obstruction, the response to conservative management is generally satisfactory. However, Schmidt[10] and Goorwitch,[19] in separate studies, reported far better results with direct duct ligation than with any other method. In our series one patient had daily thoracenteses without improvement for four weeks until closed thoracotomy was instituted, following which fluid accumulation rapidly diminished. Another patient rapidly improved on immediate closed thoracotomy. Our last patient remained on continuous chest suction for 20 days without improvement. Finally, exploratory thoracotomy was undertaken and leaking vessels at the region of the left subclavian artery were ligated. The postoperative recovery was uneventful. Most cases of postoperative chylothorax show signs of improvement within two weeks of conservative management.

Exploratory thoracotomy with visualization and direct ligation of leaking vessels is the preferred operative treatment for postoperative chylothorax. Suggested aids in localizing offending vessels include lymphography and preoperative oral administration or operative esophageal application of methylene blue and sky blue dyes.[4,10,20] With or without the application of dyes or other aids, a meticulous search for leaking vessels should be made before the chest is closed. In the event that leakage from the duct or the duct itself cannot be identified, pleurectomy and pouderage may help obliterate the fistula.[2]

SUMMARY

The authors tend to agree that the surgical approach as a primary treatment for postoperative chylothorax is rarely indicated. With strict observation of the important points in the conservative management, open thoracotomy can be avoided.

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THE BRONCHOSPASTIC COMPONENT IN PATIENTS WITH CHRONIC BRONCHITIS AND EMPHYSEMA

John K. Curtis, MD, Ashley P. Liska, Howard K. Rasmussen, and Edna M. Cree, MD, Department of Medicine, University of Wisconsin Medical Center (Drs. Curtis and Cree), and the Veterans Administration Hospital (Mr. Liska and Mr. Rasmussen), Madison, Wis.: *JAMA* 197:101–104 (Aug 29) 1966.

Clinicians frequently observe wheezing and increased dyspnea associated with exacerbations of chronic bronchitis and emphysema. In addition, during the terminal phase of chronic obstructive emphysema, the physician may be confronted with episodes of severe bronchoconstriction. Although bronchial asthma is primarily characterized by episodes of bronchospasm, it is generally held that asthma does not necessarily lead to chronic obstructive emphysema. The role of bronchospasm in the latter disease, however, has not been carefully delineated.

The authors, therefore, undertook an investigation of the bronchospastic component in 100 patients with moderate to severe chronic bronchitis and emphysema studied over a period of one to five years. Each received three or more serial tests of one second forced expiratory volume (FEV_1) before and after isoproterenol inhalation. This test was selected as a simple means of measuring constriction of the musculature of the airways with minimal influence on other factors such as vascular engorgement, mucosal edema and bronchial secretions (Hume, K. M. and Jones, E. R.: The Response to Bronchodilators in Intrinsic Asthma, Quart. J. Med. *30*:189–199, April 1961).

Results of 425 tests on 100 patients with chronic obstructive emphysema showed that as the disease progressed with advancing age, the FEV_1 gradually decreased. Nevertheless, the bronchospastic component tended to persist even though patients received bronchodilator medication (95 patients), intermittent positive pressure breathing several times daily (51 patients) and steroids (21 patients). A paradoxical reaction in which the FEV_1 deteriorated after isoproterenol was encountered in nine patients, emphasizing the importance of testing patients' response to bronchodilator medication. Eighty-four patients showed definite improvement in FEV_1 in one or more tests after isoproterenol administration. It is concluded that a bronchospastic component exists in most patients with chronic bronchitis and emphysema, whether or not a history of asthma is elicited.

CLINICAL CENTER STUDY OF CAROTID BODY TUMORS

The cooperation of physicians is requested in the referral of patients with the highly suspicious or proven diagnosis of a carotid body tumor. This study is being conducted at the Clinical Center of the National Institutes of Health by the National Cancer Institute and the National Institute of Arthritis and Metabolic Diseases. The purpose of this investigation is to relate histochemical evidence of catecholamine containing cells in carotid body tissue to excretion of catecholamines and their metabolites.

Patients admitted will be evaluated for definitive treatment. Upon completion of their study, the referring physician will be contacted concerning the indications for treatment and a cooperative decision made as to whether the treatment be best carried out at the Clinical Center or back in the hands of the referring physician.

Physicians interested in having their patients considered for admission to this study may write or telephone: Alfred S. Ketcham, M.D., Clinical Center, Room 10N-116, National Institutes of Health, Bethesda, Md. 20014; Telephone: 656–4000, Ext. 64164 (Area Code 301).

Water Intoxication Associated with Oxytocin

By JOHN J. BRENNAN, M.D., ROBERT F. MADDEN, M.D., and JOHN J. MASSART, M.D.
Milwaukee, Wisconsin

■ POST PARTUM HEMORRHAGE is commonly treated with an intravenous injection of oxytocin (Pitocin) diluted in large quantities of 5% glucose in distilled water. In these instances, a severe electrolyte disturbance may occur because blood loss is replaced with osmotically hypotonic solutions. The condition is further exaggerated by the inherent antidiuretic properties of oxytocin. Several case reports of water intoxication secondary to oxytocin infusion have previously appeared in the current literature.[1,2,3] It is our purpose to describe another similar instance featuring classical signs of oliguria, hyponatremia, and central nervous system irritability.

CASE REPORT

A 27-year-old gravida 6 para 4 was readmitted to the hospital in January 1964, with a history of profuse vaginal bleeding of 12 hours duration. Ten days before, she had delivered twins with no observable complications. Admission examination revealed a pallid, apprehensive, white female. Her blood pressure was 106/86 mmHg and her pulse rate was 96 per minute. She was afebrile and her respiratory rate was 16. Significant physical findings were confined to the pelvis. Several large blood clots and approximately 30 ml bright red blood were noted in the vagina. Placental tissue protuded from the cervical os and the corpus was large and boggy. Admission hematocrit reading was 36% and hemoglobin level 12 gm per 100 ml.

A diagnosis of post partum hemorrhage secondary to retained fragments of placental tissue was made. During the first 5 hours she received intravenously a total of 3000 ml of 5% glucose in distilled water containing 120 units of oxytocin (Pitocin). She also received 1000 ml of whole blood and 0.6 mg of methylergonovine maleate (Methergine) intramuscularly.

Despite therapy, uterine bleeding persisted. Her blood pressure fell to 60/40 mm Hg and her pulse increased to 120 per minute. Seven hours after admission she experienced a brief generalized tonic seizure. Shortly thereafter she was taken to surgery and uterine curettage under general anesthesia (cyclopropane) produced a moderate amount of placental tissue from the posterior uterine wall. Recurrent bleeding was controlled with difficulty by manual compression of the uterus. Ten units of Pitocin were injected directly into the uterus without effect. At this time plasma fibrinogen levels were reported to be 77 mg per 100 ml.

While in the operating room eight hours after admission, she developed a tachycardia of 160 per minute. Metaraminol (Aramine) was used intravenously in an attempt to maintain her blood pressure at physiologic levels. However, her blood pressure dropped to 60/30 mm Hg and the apical cardiac rate rose to 164 per minute. Respirations were irregular at 30 per minute. A portable chest film was interpreted as being within normal limits. An electrocardiogram revealed a nodal tachycardia. She was rapidly digitalized intravenously and intramuscularly with lanatoside C (Celilanid) and within two and one-half hours converted to a sinus tachycardia of 120 per minute. She remained hypotensive and her blood pressure was maintained with 5% glucose in distilled water containing 100 mg per liter of metaraminol. Subsequently, 40 units of oxytocin were added to the intravenous fluids.

She was transferred to the recovery room three hours later at which time her uterus was firm and bleeding controlled. Repeat fibrinogen levels were 264 mg per 100 ml. She remained hypotensive despite increasing amounts of metaraminol. Her stupor deepened and she became disoriented. Muscle twitching was present and hyperreflexia developed. Liquid stools and vomitus were positive for occult blood. Her urinary output for the 10 hours following surgery was 30 ml. The serum electrolytes were: sodium, 120 mEq per liter; potassium, 3.8 mEq per liter; chloride, 83 mEq per liter; and CO_2 19.1 mM per liter. Serum osmolarity was reported at 160 mOs per liter.

A diagnosis of water intoxication was made and 1000 ml of 3% saline was administered. Within 30 minutes, the patient became oriented and responsive. Urinary output during the next four hours totaled 2100 ml. The following morning she was completely oriented and alert. Blood pressure was maintained without vasopressors. Serum electrolytes at that time were: sodium, 138 mEq per liter; potassium, 4.3 mEq per liter; chloride, 107 mEq per liter; and CO_2, 28 mM per liter.

The following day her hemoglobin level was 4.4 gm per 100 ml and the hematocrit reading was 11%.

From the Departments of Obstetrics, Gynecology, and Medicine, St. Joseph's Hospital.

Melena was present, but there was no evidence of uterine bleeding. After 4 units of whole blood the hemogram rose to 8.3 gm per 100 ml and hematocrit reading 21%. She felt well and repeat hemograms rose rapidly. On the fourth hospital day she developed superficial thrombophlebitis followed by right pleuritic chest pain. There was no radiologic evidence of pulmonary infarction however and treatment was local. Follow-up chest films were also reported as normal.

She was discharged on the fifteenth day subjectively well. Her hemoglobin level was 10.6 gm per 100 ml and hematocrit reading 27%. Gastrointestinal studies failed to demonstrate a cause for her GI hemorrhage.

DISCUSSION

Water intoxication may have an insidious onset in situations where physiologic solution loss is replaced with hypotonic solutions. General manifestations include neurologic signs (stupor and seizures), muscular cramping, cardiac arrhythmias, and oliguria. Characteristic laboratory findings are hyponatremia and low serum osmolarity.

Oxytocin is a solution of purified oxytocic hormone. One ml of solution is standardized to contain 10 units of oxytocic action and not more than 0.5 unit of antidiuretic activity.[4] Certain undesirable lots of oxytocin injection have been reported to contain as much as 18 antidiuretic units per ml.

It has been demonstrated by Abdul[5] that commercially prepared oxytocin, either human or synthetic, has antidiuretic properties. When purified oxytocin is administered in rates above 45 oxytocic milli units per minute, antidiuretic properties are comparable to those of vasopressin (Pitressin). Whalley and Pritchard[3] in human experiments observed that after a water load, 10 oxytocic milli units per minute caused a minimal decrease in urine flow, 20 oxytocic milli units per minute a marked decrease in urine flow, and at a rate of 35 oxytocic milli units per minute an excretion of 5% to 10% of pre-infusion levels was demonstrated.

In these documented reports of water intoxication associated with oxytocin therapy,[1,2,3] the patients received oxytocin in saline free fluids at rates ranging from 83 oxytocic milli units per minute to 193 oxytocic milli units per minute. All presented similar clinical manifestations and responded dramatically to hypertonic saline. In this case the patient received a total of 5100 ml of 5% glucose in distilled water, 1000 ml of whole blood and 170 units of oxytocin. The oxytocin was administered at a rate of 400 milli units per minute. Her characteristic clinical manifestations cleared spectacularly with an infusion of 3% saline.

Several factors contributed to the water intoxication syndrome in this patient; (1) loss of large amounts of osmotically active solutions [blood and vomitus], (2) replacement by a large volume of osmotically hypotonic solutions [5% glucose in distilled water], (3) water retention due to the antidiuretic properties of commercial oxytocin.

SUMMARY

Physicians should be aware of the water intoxication syndrome when large doses of oxytocin (Pitocin) are employed. Clinical manifestations are disorientation, hyperreflexia progressing to seizures, oliguria, and rapidly falling serum sodium and serum osmolarity. In some instances the syndrome may attain frightening proportions in a few hours. Whenever possible, saline solutions should be used prophylactically or oxytocin should be administered slowly in concentrated doses by using an infusion pump. A clinical picture of water intoxication demands prompt therapy with hypertonic saline solutions.

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PAMPHLET: VIRUSES, COLDS, AND FLU

In "Viruses, Colds, and Flu" Dr. Michael H. K. Irwin, medical officer at the United Nations, explains how these ailments differ. He traces the development of current knowledge about their causes, treatment, and the search for immunization.

This Public Affairs Pamphlet No. 395 is available for 25¢ from the Public Affairs Committee, 381 Park Avenue South, New York, N. Y. 10016.

Surgical GRAND ROUNDS NO. 13 OF A SERIES

UNIVERSITY OF WISCONSIN MEDICAL CENTER

Co-Editors:

ROBERT C. HICKEY, M. D.
Professor and Chairman, Department of Surgery

LOUIS C. BERNHARDT, M. D., Resident in Surgery

Surgical Grand Rounds are conducted weekly as a portion of the University of Wisconsin Medical Center program in surgical education. This conference is held at 4 PM on Wednesdays in Room 300, University Hospitals, and guest physician participation is invited. Cases presented at the Grand Rounds will be published in a selective manner periodically in the WISCONSIN MEDICAL JOURNAL.

HIGHWAY TRAUMA

Discussants: WILLIAM YOUNG, M.D.
JOHN R. PELLETT, M.D.
RICHARD JONES, M.D.

Dr. Robert Hickey: Today's presentation involves a very interesting accident patient, a case of highway trauma. This patient, unfamiliar with the road on which he was traveling, found that his brakes did not work adequately and crashed into a ditch, sustaining multiple injuries. Thus he is another statistic in the present epidemic of highway accidents. Tell us his story, Doctor Kaplan.

PRESENTATION

Dr. Marvin Kaplan: Today's patient, a 32-year-old white man, was driving on an unfamiliar road early one morning in September, and, coming to a turn in the road, suddenly found himself in a ditch. He was taken, unconscious, to a community hospital and treated for mild shock. Lacerations of the face were sutured. He was given normal saline, blood, and other fluids intravenously. X-ray studies at the hospital revealed bilateral rib fractures with flailing of the sternum and atelectasis of the left lower lobe. An enlarged mediastinal shadow demonstrated feeble pulsations on fluoroscopy. The patient had a rigid, tender abdomen and absent bowel sounds. A comminuted right patella also was noted. He was transferred to University Hospitals because of suspected false aneurysm of the descending thoracic aorta.

Care of this patient at University Hospitals involved four Surgical Services: Cardiovascular, Chest, Orthopedics, and General. On admission, it was felt that the most urgent problem was his chest and abdominal injury, and accordingly, he was transferred to the Thoracic Surgery Service. Preoperative diagnosis was a laceration of the liver.

At laparotomy the ascending colon was found to be traumatically ruptured in three locations, some areas of which were gangrenous. The liver was normal and no other abdominal injuries were apparent. A right hemicolectomy was performed and at the termination of the procedure a tracheostomy was done to facilitate control of the flail chest.

Following surgery, the patient did remarkably well. He was supported on a Bird respirator for several days postoperatively because of his flail chest and the need for suction.

For a period of six days postoperatively, x-ray films of the left chest showed a progressive opacity. As it was evident that the patient's chest and abdominal problems had stabilized, his vascular problem was now considered. A forward aortogram was obtained, demonstrating a normal descending thoracic aorta up to the left subclavian artery, where there was a sudden bulging. This was interpreted as a traumatic rupture. The patient was again taken to the operating room, put on total heart-lung bypass, and repair of the descending thoracic aorta accomplished below the left subclavian artery by the insertion of a woven Teflon graft between the divided ends of the aorta. Bruises were noted on the myocardium and in the ascending aorta.

Postoperatively, the patient again did exceedingly well. He was next treated by Orthopedics, where his patella was excised and a tendon repair accomplished.

Eight weeks after his accident the patient was discharged from the hospital. He has been seen in the Outpatient Clinic twice, and is growing progressively stronger.

From the Sections of General, Thoracic, and Cardiovascular Surgery.

Doctor Hickey: This man's problem was that of blunt trauma to the colon, a flail chest, a very major vascular injury, and one relatively minor fracture. Doctor Jones, would you comment on your interpretations and the management of the more pressing situations at the time we first saw this patient?

DISCUSSION

Dr. Richard Jones: We saw this patient on the afternoon of the day of admission, and he had an acute abdomen. The exact cause was unknown, but surgery was obviously required. He was explored the same afternoon. There was no free blood in the peritoneal space with the exception of the right gutter, and the bowel was necrotic in the ascending colon, with several small perforations. There was no gross contamination of the peritoneal cavity at that time. We performed a right hemicolectomy. Postoperatively, with the exception of his chest problem, he did very well.

At this time, the patient had difficulty respiring adequately. He was intubated for the surgical procedure. Rather than leave the endotracheal tube in place and continue with the Bird respirator, we elected to perform a tracheostomy. A moderate amount of secretions occurred and were easily removed via the tracheostomy; the operation adequately handled the patient's respiratory problems.

Doctor Hickey: Doctor Young, I have four questions which I think would be of general interest. What sign first indicated to you an aortic rupture, and how soon was this diagnosis made? What are the dangers of delay in such cases? How necessary is it to actually use the heart-lung bypass procedure? What would be the results if such a patient were not explored?

Dr. William Young: The mediastinal shadow on his chest x-ray film was recognized as being abnormal in the community hospital. Fluoroscopic examination there revealed this shadow to pulsate feebly. One of the traumatic lesions of the great vessels in the mediastinum with which a patient occasionally survives is the transection of the aorta. The intima and media completely separate. The continuity of the aorta is maintained only by the adventitia, which retains clotted blood and is often strong enough to retain the blood under pressure over an extended period of time. This type of separation can occur in other parts of the aortic arch, but it is most frequent just distal to the origin of the left subclavian artery. This was the working diagnosis; it was not documented until the aortogram was done five days after the accident and colon resection.

The dangers of delay that must be weighed in the face of such a diagnosis are relative. Most such fractured aortas have been repaired late when an aneurysm is present because the diagnosis has not been made at the time of injury. We have the undocumented impression that most patients who survive the initial injury will live to develop chronic aneurysm. As the patient could be observed constantly and aortic surgery accomplished with very little preparation, aortic repair was not considered urgent.

Aortography was carried out five days post-accident, the patient being reasonably stable. We planned to repair the aorta when the patient was in better physical condition and the inflammatory mediastinal reaction had cleared. On the eighth day post-injury, the left side of the chest became dull to percussion and opaque to x-ray examination. At the time of surgery, however, there was no evidence that there had been any recent bleeding from the mediastinum. The pleural fluid was largely sanguinous but not fresh, and the inflammatory reaction was severe.

Bypass is essential in such aortic surgery. If a bypass of some sort is not used, the spinal cord would be unacceptably vulnerable, no matter how short the duration of cross-clamping of the aorta. If clotting is prevented by heparinizing the patient or using a graphite-benzalkonium-heparin coated tubing, the patient's own blood pressure can perfuse the lower body from the subclavian artery, but the flow from the aorta to the subclavian artery must not be compromised. A pump performs a similar job with the blood from a tube in the left atrium, and is generally considered more dependable. The severe bleeding from the dissection in the inflamed mediastinal tissues was handled adequately by sending this blood loss through the pump-oxygenator and adding it to the left atrium-to-femoral artery perfusion.

If the aorta had not been repaired at this time, it is most likely that the patient would

Fig. 1—Routine x-ray film showing false aneurysm.

Fig. 2—Appearance of aneurysm at thoracotomy.

Fig. 3—Upper half of surgical specimen.

Fig. 4—Open end of aorta.

have recovered to a state approximating normal. The adventitia, however, with its contained clot, would have become organized and fibrosed. This fibrous tissue, lacking elastic tissue, would have gradually stretched out over a period of years into a sizable progressively enlarging false aneurysm.

Earlier we had a patient in whom such a false aneurysm was discovered on a routine x-ray film taken during pregnancy (Fig. 1). In a retrospective history, it was determined that she had been in an automobile accident 11 years earlier. The only x-ray films still available taken at that time were spot films of broken ribs and of her left shoulder. Although connective tissue tends to yield to force during the latter part of pregnancy due to the effect of the relaxin-like substance, it was elected to carry her through the pregnancy without surgery.

There was some increase in size of the aneurysm, and three months after delivery she came to elective repair. Figure 2 shows the appearance of the aneurysm at the time of the thoracotomy. The surgical specimen was removed in two parts, the upper half of which is shown in Figure 3. The end of the transected aorta projects into the aneurysm cavity. Figure 4 shows the other open end of the aorta. Typically, it appears to be folding back into itself along with the flow of blood, and this almost certainly accounts for the musical quality of the systolic murmur that is sometimes present in such cases.

Dr. John Wear: How much blood was present in the chest of today's patient, Doctor Young?

Doctor Young: There were 1500 to 2000 ml of blood present, but it was serosanguinous rather than from fresh bleeding.

The flail chest in today's patient was a bit more of a problem than has been emphasized. The chest was quite unstable. We kept him on a volume-controlled respirator for more than a week after the repair of the aorta, and had some difficulty weaning him from the respirator due to paradoxical movements of the entire anterior chest wall. It was essential that he have a tracheostomy established soon after the injuries. He appeared to have had every rib broken on both sides anteriorly.

It is of some interest that at the time of laparotomy, no air, blood, or other fluid was found where it would have been obtained on needle aspiration of the peritoneal cavity; yet the patient did have a perforated colon, making laparotomy essential.

Doctor Hickey: Doctor Pellett, would you like to comment further on the surgical hemicolectomy procedure?

Dr. John Pellett: Prior to surgery, one diagnostic method which could be employed would be to do an abdominal paracentesis to check for free blood or intestinal fluid within the peritoneal cavity indicating a perforation. However, in this situation, it became obvious that the patient had an acute, rigid, tender abdomen, and that a laparotomy was mandatory, making it unnecessary to employ this diagnostic procedure.

Having decided that surgery was definitely necessary, we proceeded without delay. As described by Doctor Jones, trauma to the ascending colon was found requiring an emergency hemicolectomy. This was accomplished in a routine manner with essentially no complications in the postoperative period. Treatment of choice for the severely flailed chest was tracheostomy, performed prior to leaving the operating room. The Bird respirator was employed nearly continuously for the first several days postoperatively.

This young man was extremely fortunate in the favorable outcome of a very severe injury requiring major surgery on his abdomen, stabilization of his flailed chest by positive pressure methods, and aortic resection for the traumatic rupture.

Doctor Hickey: I would like to ask the patient a few questions. I would like to know what type of highway you were on, what the condition of the highway was at the time, if there were any mechanical failures in your vehicle, and what your condition was at the time.

Patient: I was out for the evening. I was not familiar with the road; seeing what appeared to be a corner or a dead end, I stepped on the brakes. They didn't work. My car had power steering, power brakes, and automatic transmission. When I stepped on the brakes and took my foot off the gas pedal, the motor died. There was no drag through the transmission, no power steering, or brakes. I saw that I was going to hit, so I jammed both feet on the brakes, and I left 40 to 50 feet of skid marks behind me before I hit the bank.

Doctor Hickey: What type of highway was this?

Patient: A county blacktop.

Doctor Hickey: The highway was not particularly slippery and there was no fog at that time?

Patient: There had been a slight shower earlier, but I don't remember noticing if the highway was damp.

Doctor Hickey: Were you wearing a seat belt?

Patient: No.

Question: Had you ever had a previous accident?

Patient: Yes, I broke my neck in an accident nine years ago.

Doctor Hickey: Highway trauma has risen to epidemic proportions. This year approximately 1075 persons died in Wisconsin. A Federal Highway Safety Act was passed this year to focus upon the problem, and Wisconsin is studying a comprehensive safety program.

This man was traveling, as I interpret it, on a town road system, where 7.6% of the total miles are traveled, and where 29.7% of the accidents occur. If he were on a county road, the miles and accidents (about 20% each) would be equal. He's done well. He's another statistic—but not a fatal one because of great concerted effort by all the cooperating surgical services.

PATIENTS WITH MULTIPLE SCLEROSIS ARE NEEDED FOR TREATMENT EVALUATION BY MARQUETTE UNIVERSITY STUDY

THE EVALUATION OF therapy in multiple sclerosis has always been a difficult problem. The nature of the illness hinders on objective evaluation. Recently, a multiple sclerosis study has been created by the National Institutes of Health incorporating the talents at eight neurological centers around the country. These include centers in New York City, Cleveland, Boston, Washington, D.C., Los Angeles, Burlington, Vermont, and Ann Arbor, Michigan. In December 1966, the Department of Neurology, Marquette University School of Medicine was made a part of the study. The study is under the general chairmanship of Dr. Augustus Rose, Professor of Neurology at UCLA, where a computer analysis center has been established. A rigid protocol has been designed to permit the objective evaluation of therapy in multiple sclerosis based on rigid diagnostic criteria and uniform utilization of quantitative neurological evaluation methods.

The initial study of this group will be designed to evaluate the effectiveness of ACTH in patients with an acute exacerbation of multiple sclerosis. ACTH has been extensively used by clinicians in the treatment of multiple sclerosis, but, generally, without the support of statistically valid studies or a quantitative assessment of neurologic changes before and after treatment in comparison with control groups. For this study, suitable patients with multiple sclerosis will be admitted to the Clinical Research Center, Marquette University School of Medicine located in the Milwaukee County General Hospital. They will be hospitalized for two weeks, during which time they will be given either ACTH or the gel in a double-blind fashion. An evaluation of their status will be undertaken before, during, and after therapy at specified intervals, and utilizing specified evaluation techniques. Comparisons will then be possible between patients on ACTH or those on the gel with respect to changes in neurologic findings and symptoms in terms of functional capacity.

Only certain types of multiple sclerosis patients can be considered eligible for this study. For this reason, the cooperation of the practicing physicians, in and around this area, is earnestly solicited. The rights and welfare of the patients will be sincerely protected at all times. They will be fully informed as to the nature of the study. None of the methodology being used is experimental in nature. Further, the relationships established between the referring physicians and the patient will be respected at all times. The referring physician will be welcomed to continue following his patient during the study if he so desires. At the completion of the study, the patient will be returned to the referring physician with a full report.

Patients desired for the study are those with the following characteristics:

1. An established or strongly suggestive diagnosis of multiple sclerosis, excepting those so severely disabled as to be unable to ambulate, dress, or feed themselves without assistance.
2. An acute exacerbation of symptoms or signs of less than eight weeks duration.
3. No ACTH or steroid therapy within three months of enrollment in the study.

The study will be conducted under the personal supervision of the principal investigator, Philip T. White, M.D., Chairman of the Department of Neurology and/or the co-investigator, Mario de Oliveira, M.D., a member of the full-time faculty of neurology. The study will be conducted at no cost to the patient.

For further information or referral of patients, please contact:

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The Second Messenger

By DEANE N. CALVERT, Ph.D.

Milwaukee, Wisconsin

■ THE IDEA THAT the hormones of the anterior pituitary (adenohypophysis) act as messengers from that gland to another gland (target organ) is well established and well documented. The function of the messenger is to stimulate the endocrine gland to secrete its hormone into the blood. The well established trophic hormones are ACTH (adrenocorticotropic hormones), TSH (thyroid stimulating hormone) and the two gonadotropic hormones LH (luteinizing hormone also called ICSH, interstitial cell stimulating hormone) and FSH (follicle stimulating hormone). Although it has been clear that these hormones do indeed stimulate the output of cortisol, thyroid hormones, progesterone and estrogen (or testosterone) respectively, the events which occur within the target gland following the arrival of the trophic hormone until recently have remained obscure. However, the concept of a second messenger has arisen in the last few years. In the context of this hypothesis, the ubiquitous nucleotide adenosine triphosphate (ATP) is believed to be converted to a newly discovered nucleotide—cyclic 3'5' adenosine monophosphate (cyclic AMP)—through the action of an enzyme adenyl cyclase. The trophic hormone is believed to stimulate the production of cyclic AMP in the specific target gland and not in other organs. The cyclic AMP thus formed then acts as a second messenger in that gland stimulating the output of the second hormone.

To trace the origin of this idea, we must examine still another hormone—epinephrine. This amine, produced by the medulla of the adrenal gland, has among its many actions the stimulation of the output of glucose from the liver. The mechanism of this hyperglycemic action of epinephrine eluded discovery for many years principally because it was impossible to show the effect after rupture of the hepatic cell membrane.

Doctor Calvert is Associate Professor of Pharmacology, Marquette University School of Medicine.

COMMENTS ON TREATMENT

Presented through the cooperation of the Department of Pharmacology, Marquette University, Milwaukee, and the Department of Medicine, University of Wisconsin, Madison

HAROLD F. HARDMAN, M.D., Ph.D., Co-Editor
Marquette University School of Medicine

OVID O. MEYER, M.D., Co-Editor
University of Wisconsin Medical School

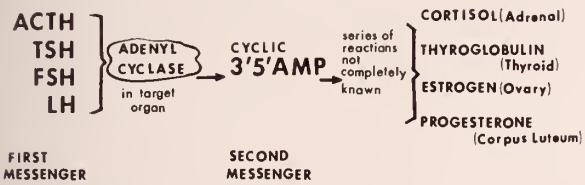
However, in 1957, Sutherland and his collaborators[1] found that it was possible to obtain the increase in glucose production by a homogenate of liver. In a series of brilliant publications, these workers successively showed that there was a coenzyme formed and that its structure was a cyclic adenine monophosphate, that there was an enzyme which formed this coenzyme and which they named adenyl cyclase, and that under proper circumstances epinephrine could stimulate the enzyme to produce a greater amount of the new coenzyme. Moreover, they discovered the presence of still another enzyme which inactivates the coenzyme—phosphodiesterase.

In the same institution, Haynes,[2] inspired by the sequence of steps unfolding in the liver, felt that the adrenal cortex may be under a similar control system. The experiments he devised showed that ACTH could increase the production of cortisol in homogenates of adrenal gland. He further showed that cyclic AMP could stimulate (and therefore substitute for ACTH) the production of cortisol. More recent evidence indicates that ACTH can increase the level of cyclic nucleotide in the adrenal cortical tissue. The question of specificity was immediately raised and answered. It appears that epinephrine will not stimulate the production of cortisol in the adrenal nor will ACTH stimulate glycogenolysis in the liver.

Following these demonstrations it became obvious to examine the other trophic hormones for their possible effect on the formation of cyclic 3'5' AMP in their target organs. Although details are not yet available for all of the steps in the processes in each organ, it is clear that TSH stimulates the production of cyclic adenosine mono-

phosphate in the thyroid and that the gonadotropins do likewise at their respective sites of action.

It is possible to diagram the sequence of reactions which occur as follows:



Once again one wonders about the specificity of the initial reaction—the stimulation of adenyl cyclase by the appropriate hormone. It has been suggested that adenyl cyclase may be quite distinct in the different tissues and amenable to stimulation only by the specific trophic hormone. Since the trophic hormones are all protein in nature and of high molecular weight, the question of penetration to the site of adenyl cyclase was also raised. However, the evidence seems clear in several systems that the enzyme is located near or upon the membrane of the cells of the target organ.[3]

The significance of these pioneering experiments is difficult to overestimate. The concepts involved are new and important. The potential value which will accrue from the basic understanding of the biochemical events occurring between arrival of a trophic hormone and the release of a second hormone is inestimable. The door has been opened to more rational therapy of the many endocrine disorders which until now have been treated by somewhat successful empiricism.

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PULMONARY RHEUMATOID NODULE WITH CAVITATION AND CHRONIC LIPID EFFUSION

Bruce F. Stengel, MD, Raymond R. Watson, MD, and Ronald J. Darling, MD, Surgical Service, Wood (Wis) Veterans Administration Hospital, and the Division of Surgery, Marquette University School of Medicine, Milwaukee: *JAMA* 198:1263–1266 (Dec 19) 1966.

Doctors Bruce F. Stengel, Raymond R. Watson and Ronald J. Darling from the Surgical Service of the Wood Veterans Administration Hospital and the Division of Surgery of the Marquette University School of Medicine presented a case report in the Dec. 19, 1966, issue of *The Journal of the American Medical Association.* The paper was entitled, "Pulmonary Rheumatoid Nodule With Cavitation and Chronic Lipid Effusion."

Unusual findings were noted in a patient with nodular rheumatoid pulmonary disease with roentgenographic evidence of cavitation. Biopsy specimen of the cavitated nodule was identical microscopically to the patient's typical subcutaneous rheumatoid nodule. Of further interest was the associated pleural effusion and low glucose concentration, high total lipid content, and extremely high lactic acid dehydrogenase level. The authors believed that chronic lipid effusion and elevated lactic acid dehydrogenase had not been previously reported in association with rheumatoid diseases of the lung.

They concluded that the diagnostician must consider rheumatoid disease in the differential diagnosis of cavitary pulmonary lesions in the patient with associated rheumatoid disease. Adequate biopsy and microscopic confirmational process are still required for definite diagnosis.

Resolution of rheumatoid pulmonary infiltration, both with and without treatment, has been reported. Their patient had no specific therapy directed toward his pulmonary disease postoperatively and has shown no change or progression in the pulmonary component of his disease. Pleural effusion did not recur after surgery.—V. S. Falk, M.D.

PAMPHLET: REHABILITATION COUNSELOR

In "Rehabilitation Counselor: Helper of the Handicapped," Miss Elizabeth Ogg portrays the work of the rehabilitation counselor in helping people with physical, psychological, or mental handicaps. She also includes information on undergraduate and advanced training, salaries, and career opportunities.

This Public Affairs Pamphlet is available for 25¢ from the Public Affairs Committee, 381 Park Avenue South, New York, N. Y. 10016.

A TRIPLE ASSAULT on the disabilities resulting from strokes has been launched by the Veterans Administration hospital at Durham, North Carolina in cooperation with the Duke University Medical Center with the financial assistance of the National Institutes of Health.

SPECIAL TO THE JOURNAL

Implications of Proposed Changes in Audiometer Calibration Specifications

By CHARLES A. TAIT, Ph.D.
Madison, Wisconsin

THE FOLLOWING ARTICLE was written by Charles A. Tait, Ph.D., Clinical Audiologist, at the request of the Division on Visual and Hearing Defects of the Commission on State Departments of the State Medical Society. The purpose of the article is to call attenion to and acquaint Wisconsin physicians with the change in the Zero Reference Level of audiometers. Numerous scientific groups concerned with audiometric measurements, including the American Academy of Ophthalmology and Otolaryngology, American Otological Society, the American Laryngological, Rhinological and Otological Society and the American Speech and Hearing Association, have recognized that the new International Standard Zero Reference Level (I.S.O. 1964) as being more truly representative of normal hearing than the previously used 1951 American Standard Zero Reference Level. These organizations have therefore adopted the I.S.O. Standard and have recommended the change to their membership. While there has been some objection and delay in making this change, the transition is taking place as indicated by Doctor Tait. It is extremely important, therefore, that physicians who perform and interpret audiograms be familiar and understand the full significance of this change in order to avoid misunderstanding and confusion.—Meyer S. Fox, M. D., Chairman of the Division on Visual and Hearing Defects

THE MAJOR PURPOSES of this paper are: (1) to acquaint Wisconsin physicians with recent proposed changes in audiometer calibration specifications, (2) to outline the implications of changing audiometer calibration standards, and (3) to offer specific recommendations regarding audiometric procedures and interpretation of audiograms under the new standards.

HISTORICAL BACKGROUND

In December 1964, the Committee on Conservation of Hearing of the American Academy of Ophthalmology and Otolaryngology approved in principle a change in audiometric calibration standards. Shortly thereafter, the American Speech and Hearing Association formally endorsed the position of favoring such a change, and announced that 1965 should be the year of transition. Although an immediate reaction of confusion and rejection of the proposal by industry was formidable, when the furor settled down a rather smooth transition from present calibration standards to the proposed ones occurred. By September 1966, most university hearing centers and hospital clinics, and virtually all Veterans Administration hearing clinics had switched to the new calibration specifications. Recently, the Wisconsin Audiology Conference recommended that all hearing-testing centers in Wisconsin adopt the new calibration standards by September 1966.

AUDIOMETRIC CALIBRATION

Audiometers are calibrated in decibel units relative to a zero decibel level, which in turn is based on auditory physiology rather than a physical standard. Thus, an audiometer dial reading of zero dB indicates a tone barely audible to the average normal-hearing individual. Since the ear is not equally sensitive to all frequencies, zero dB dial reading represents a different sound pressure at each frequency.

Traditional calibration standards for audiometers in the United States are based on a U.S. public health survey of 1935–1936, and are written up in American Standards Association documents (ASA–1951). The newly adopted audiometer calibration specifications result from 15 different studies done in five countries, and are specified by the International Organization of Standards (ISO–1964). The decibel difference between the ASA specifications and the ISO recommendations were clearly specified by Davis and Kranz in 1964.[1,2] This difference is as little as 5 dB at some frequencies and as much as 15 dB at others. The average decibel difference in the speech frequencies (500, 1000, 2000 cps) is 11 dB. *This means that a patient's hearing loss will appear to be more severe when thresholds are determined on an audiometer calibrated to ISO specifications.*

Although Davis and Kranz urge audiometer-users to have their audiometers recalibrated to meet ISO specifications, an alternative is offered. Those wishing to use audiometers calibrated to ASA standards need only determine thresholds in the usual manner and then *add* the specified decibel amounts to the *hearing loss* (Table 1).

TABLE 1—*Decibel differences between ASA 1951—ISO 1964.*

Frequency	250	500	1000	2000	4000	6000
Decibel Difference	15	14	10	8.5	6.0	9.5

Doctor Tait is Clinical Audiologist in the Department of Otolaryngology, University of Wisconsin Medical Center.

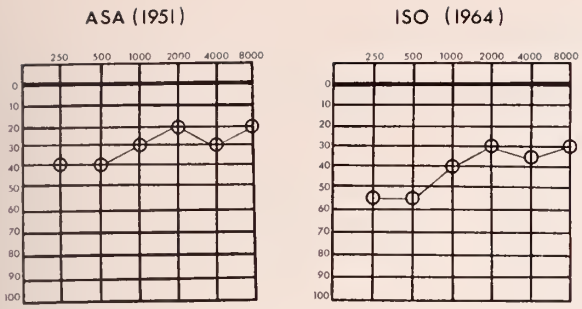

Fig. 1—Audiometric configurations illustrating patient with a mild hearing loss. The audiogram labeled ISO-1964 was drawn by converting ASA-1951 hearing levels via the "decibel difference" table.

Conversely, to convert an audiogram marked "Hearing Threshold Levels—ISO, 1964" to equivalent ASA decibel values one can *subtract* the "decibel difference" values from the hearing loss. The audiograms shown in Figure 1 illustrate a hypothetical patient with a mild hearing loss. Although the audiometric configurations and severity of loss appear dissimilar, both audiograms indicate *identical* hearing impairment.

PERTINENT CONSIDERATIONS

Physicians employing audiometric techniques for screening hearing usually test in a quiet setting to minimize background noises which interfere with low frequency test tones. Hearing thresholds determined in a noisy environment are often substantially poorer than those obtained in a quiet setting. With ISO calibrated audiometers, it is imperative that a *very* quiet test environment be employed since tones at each decibel level are less intense than when calibrated to ASA specifications, and consequently more susceptible to noise interference.

Davis,[3,4,5] in 1965, stressed the concept of a normal *range* of hearing rather than a single hearing threshold level. The normal range of hearing ASA—1951 is from —10 dB to +15 dB while the normal range ISO—1964 is from 0 dB to 25 dB. In relating hearing threshold levels to hearing impairment, Davis states:

> Actually, *handicap is generally conceded to begin at about the upper edge of the range of normal, and more specifically at 27 dB* (ISO) or 16 db (ASA, 1951). We refer here to the average hearing threshold level for the three frequencies 500, 1000, and 2000 c/s. *The percentage handicap is not proportional to the number of decibels that an individual's hearing threshold lies above the audiometric zero nor does it depend in any way on which audiometric zero is used to describe that threshold.*[5]

Thus, it will be necessary for physicians to reorient themselves to the different relationship between hearing loss on the audiogram and *hearing impairment.*

RECOMMENDATIONS

In view of the considerations offered above, the following recommendations seem appropriate: (1) all audiometers should be recalibrated to ISO specifications, or testers should make necessary conversions via the "decibel difference" table to the new standards; (2) strict attention should be given to providing as quiet a testing environment as possible; (3) all audiograms should be clearly labeled "Hearing Threshold Levels, ISO—1964" or "Hearing Levels, ASA—1951," and (4) nurses or technicians should be urged to read one or more of the referenced journal articles which provide a more complete explanation of the new calibration specifications.

1300 University Ave. (53706).

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* * *

"NEGATIVE PLACEBO RESPONSES?". We observe that medicinals have an effect regardless of the composition of the substances contained within them. And further, we know that the placebo effect is not always favorable in terms of therapeutic response. It is my conviction, as I have suggested earlier, that many of the "side effects" ascribed to various medications are, in fact, what can be called "negative placebo responses". It is not at all rare, for example, to observe adverse reactions following the administration of drugs—reactions which have nothing whatsoever to do with the pharmacological properties of the drug, but very much to do with the psychological factors which neither patient nor doctor nor nurse are very much aware. One of the most amazing events in medical practice is to observe a "side effect" from nothing more potent than a sterile hypo, or even from nothing more pharmacological than a venipuncture. —Gordon R. Forrer, M.D., in *Michigan Medicine*, 63: 8 (August) 1964.

MEDICARE Report No. 4

How to Apply for Medicare Part B Benefits

This pamphlet is a simple explanation of how Medicare claims are paid by the non-assignment method. It shows in detail what part of the SSA 1490 claim form is completed by the patient and also what information is needed from the doctor for the patient to send along with the 1490 claim form.

On the inside of the pamphlet is a full-size 1490 form correctly completed. You may use this form to instruct patients how to complete the SSA 1490 correctly.

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THE PRESIDENT'S PAGE . . .

FRANK E. DREW, M.D.
Milwaukee

Sublime to the Ridiculous

■ MEDICINE AS A profession is dying! Medicine as a science is progressing! This incongruous statement is true and due to the changing times, and the inroads made by third party interference. The art of medicine has shown the greatest scientific progress in the past quarter century, and all these developments have alleviated suffering and prolonged the life span of the human race. Medical scientists and practicing physicians have been honored and praised for these recognized accomplishments. Through modern methods the possibility of extending the span of human life has almost reached the stage of fantasy. The average citizen reads of this progress and appreciates this progress, but little does he realize what is happening to medicine as a profession. He does not realize what limitations may be placed on his selection of physician or his place of treatment in the years to come. His physician may be helpless to direct his contact with the patient or maintain his personal relationship with him.

Many physicians because of their professional activity have been lulled into a state of complacency! It could not happen here in this country, is their attitude. They have been so busy using the new drugs and techniques that they have not realized what is happening to them as individuals, as physicians, or to the free enterprise system they now enjoy. They are accomplishing great feats for their patients, but they are paying dearly for the lack of interest in self-protection for their own welfare. The terms of defeat which we have sustained are still being extracted through directives and guidelines. What the medical profession had tried to prevent by hope has now become a reality. The concern and battle that once was nationwide now has settled into the area where you practice. To mourn for what has happened in the past and is now gone, is only to ask for more of the same.

Physicians are known to be the "poorest type of businessman in any field of endeavor." This phrase is now here to haunt us, and it is now time to prove that this may have been true in the past, but not for the future. No longer can physicians be busy just dispensing their great scientific knowledge and let the business side of medicine develop a crippling paralysis. Good bone structure—but no muscles for defense. We are being attacked and assaulted from all sides. Organizations, people, and the administration on all levels are the facets of this crippling disease condition. We are now in the process of losing our freedom of practice. The inherent rights to direct our destiny, protect our rights as physicians and citizens, is gradually being usurped. Time is running out on our chance to react.

The boldness of the destroyers of the business side of medicine is seen almost daily in the press and other forms of news media. The giant federal programs of medical care are sapping the life out of the business side of our chosen profession. Regimentation is already upon us as seen in the many directives we have to comply with now. Namely, the filling out of many forms, the disclosing of confidential patient–physician information, and the passing on of our fellow physician's method of treating his patients. You comply with these regulations or you receive no payment for your services. The regulation of your charges for these services is subject to scrutiny and regulation.

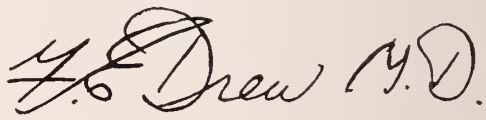
PRESIDENT'S PAGE *continued*

Because of all these processes, men of medicine are having a strange image created by these agencies and various individuals which seems to border on the verge of dishonesty and questionable integrity. We have been accused of increasing the cost of medical care and also hospitalization in spite of the presence of inflationary spirals. These images are damaging and create many improper situations in the viewpoint of the public. We are being "whipped" for asking for our just rights and compensation.

We are at the present like the professional fighter who has taken his beating and one more good blow and he will hit the canvas. Just what is the answer to this problem or is it almost insurmountable? We must stop being "ethereal physicians" and come down to earth with fortitude and realize what has happened to us so far, and what can be definitely in the offing.

Labor at the turn of the century was faced with the same dilemma. They had the choice of being peons or rise and organize to defend their rights against management. They organized and operated as a unit; their just benefits and rights have been preserved; and their accomplishments are now well known and established. Their right to unit action financially and politically is not questioned.

Men of science may not like this thought that unionization of the field of medicine is the answer, but the stage of tolerance is gone. I personally recommend that we give this thought a "hard look." By this type of action it has been proved that this is the only way to successfully correct injustices, preserve rights, and demand just recognition. The public approves and understands this type of logic. Rome burned while Nero fiddled, and half the house of medicine has already burned and been destroyed. We need a new concept of organization and we need it now, not years hence when we have nothing left to preserve.



SYMPOSIUM AND BOOKLET ARE PUBLISHED ON HYPERTENSION AND RELATED PROBLEMS

The proceedings of the 1965 scientific sessions of the AHA Council for High Blood Pressure Research and a new publication intended as a reference for physicians in office treatment of hypertensive patients have been published by the American Heart Association.

Entitled "Hypertension—Neurohumoral Mechanisms and Vascular Smooth Muscle," the Council's symposium consists of 15 articles describing in detail new data on this subject. Number 14 in the Association's Hypertension Series, the 180-page volume was edited by Dr. J. Edwin Wood, who also wrote a foreword.

The new booklet, "Drug Treatment of Arterial Hypertension," discusses drugs in common use for treating this condition. A summary chart indicates action, side effects and dosage for all drugs discussed. The publication was prepared by Drs. Harriet P. Dustan and Irvine H. Page of the Cleveland Clinic Foundation for AHA's Committee on Medical Education.

"Hypertension - - -" may be obtained through the AHA National Office and "Drug Treatment - - -" may be obtained from the Wisconsin Heart Association, 205 W. Highland Ave., Milwaukee, Wis. 53203.

REPORT: SPINAL CORD DYSFUNCTION

The Institute of Rehabilitation Medicine, New York University Medical Center, has announced publication of a new report entitled "Spinal Cord Dysfunction."

Co-authored by Drs. Lawrence Kaplan, Bruce B. Grynbaum, Howard A. Rusk, and Miss B. Ruth Powell, the report is a comprehensive follow-up study of spinal chord dysfunction and its resultant disabilities, conducted under a grant from the Vocational Rehabilitation Administration, Department of Health, Education and Welfare.

The contents of the study include separate chapters on neurological data, endocrine and metabolic findings; decubiti; self-care activities and self-help equipment; nursing care; psychological reactions; sexual adjustment, identification, and attitudes; social adjustment and vocational rehabilitation.

Single copies of the 184-page book are available upon request without cost from the Publications Unit, Institute of Rehabilitation Medicine, New York University Medical Center, 400 East 34th Street, New York, New York, 10016.

* * *

OBSERVATION OF subcellular functions by the electron-microscope is providing basic and exciting results in medical research at the Veterans Administration hospital in Washington, D. C.

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EDITORIALS

D. N. GOLDSTEIN, M. D., *Editorial Director*

Hospital High Rise

■ A LOCAL MACHINISTS UNION recently passed a resolution asking that the State Legislature be petitioned to put hospitals under regulatory control because hospital charges were getting too high. While some of the formidable array of "whereases" that preceded the resolution may be open to question because of the misinterpretations they represent, the fact of the resolution is too significant to be casually dismissed.

The machinists alluded to the concentration of medical services into large, complex facilities thus creating a monopoly which "defies any outside influence or competition." While this statement presupposes that the cost of medical service is subject to the same kind of competitive pressures that prevail in the marketplace of commodities, it nevertheless remains true that hospital costs have risen with little regard for the ability of the patient to pay either the actual costs or the increased premium of the insurance required to cover the costs. The mysteries of hospital cost accounting stay in the deep, dark arcana of hospital administration, and too seldom has there been any precise statement as to the justification for hospital costs.

All of this might be futile fulmination if it were not for the recent statement of Dr. Philip D. Bonnet, former president of the American Hospital Association, that hospital costs may increase by as much as 25% in the next year. If hospital costs continue to escalate at the same rapid rate, the machinists may soon be joined by other labor groups, and followed by a host of civic organizations demanding that the government control an invidious inflationary spiral. When this happens, the kid glove approach of the present medicare law could easily be replaced by a more stringent control mechanism that would make hospitals nothing more than agencies of the federal government.

Of all the uncertainties of life, one of the most fearful for the average citizen is that which attaches to illness. The physical consequences of illness or accident are terrible enough, but the economic result is apt to be horrifying. Protected to a degree by insurance and government social security, many otherwise financially secure people know they can sustain illness of moderate duration or complexity without economic ruin. But if the illness is chronic or requires elaborate therapy, present day medical and hospital

costs can wipe out a lifetime of thrifty planning. How long people are going to complacently watch medical and hospital costs continue to rise beyond the general inflation of the economy is an open question.

The problem involves doctors as well as hospitals. Whether we like it or not, medical costs seldom become separated from hospital costs; both are categorized under health care costs. A voluntary restraint must be placed on both.

Operating efficiencies, office economies, elimination of luxuries and a careful examination of cost accounting would undoubtedly go far to reduce the cost of providing health services so that a further increase in prices may be unnecessary. A determination to keep expense down in the hospitals and a realistic assignment of costs may easily underly a leveling off and possible reduction of hospital prices.

Some creative imagination and medical engineering are required in America's health care complex to keep its cost within reach of the people it is supposed to serve. It's no trick to let prices mount as our institutions become more complex. The trick is to improve the service without increasing the price. If we don't manage to do it, a lot of people besides the machinists union will be calling for government control.—D.N.G.

Doctor, Are You Guilty?

EDITOR'S NOTE: *This was an open letter to Dane County physicians, written recently by C. K. Kincaid, M.D., President of the Dane County Medical Society. Because its message is pertinent to all of us, it is being reprinted below.*

A RECENT NEWS headline mentions 300% increase in physician fees. Another states "County Surgeons' Fees Increasing 30 to 35%." For several years prior to enactment of Medicare law the public has been fed news over and over regarding the high and increasing cost of "medical care". And to most people, medical means physicians.

This campaign has not only inoculated the public with distrust of the finest profession, but has also made each of us feel guilty. In this letter I am only concerned with your own morale. Such guilt feelings could interfere with your rapport with your patients. A demoralized practitioner, or one who has lost some respect of and rapport with his patients cannot practice the best medicine of which he is capable. As you have heard me say for years, public health is based on good medical practice.

Sure, your fees have gone up . . . *but they have still lagged behind the overall cost of living!* Note the latest figures on the attached table (see page 149)—and be proud again!

SUPPORT YOUR FOUNDATION

It is your opportunity to give financial assistance to the charitable, educational and scientific aspects of medicine as they relate to the health and well-being of the people of Wisconsin. Gifts may take a number of forms such as cash, life insurance, securities, land, books, instruments, stamp and coin collections, works of art and other artifacts. Some physicians are making the Foundation a beneficiary of their wills. In any event, all contributions to the Foundation are deductible for income tax purposes. Checks may be made out to: CES Foundation, and sent to CES Foundation, State Medical Society of Wisconsin, Box 1109, Madison, Wisconsin 53701.

Consumer Price Index–United States City Average

(1936 = 100)

Date	All Items	Medical Care	Physicians' Fees	Dentists' Fees	Hospital Fees
1936	100.0	100.0	100.0	100.0	100.0
1937	103.5	100.8	100.6	102.3	102.5
1938	101.7	101.2	100.4	102.5	105.0
1939	100.2	101.2	100.6	102.7	105.4
1940	101.0	101.4	100.6	102.7	105.8
1941	106.2	102.0	100.9	102.9	107.9
1942	117.6	104.8	103.0	105.6	116.7
1943	124.8	109.9	109.6	110.4	125.8
1944	126.9	113.3	114.0	116.5	131.3
1945	129.8	115.9	116.8	121.5	135.4
1946	140.8	122.4	122.5	128.6	154.2
1947	161.1	132.5	130.4	139.3	183.8
1948	173.5	140.7	135.6	146.8	214.6
1949	171.8	145.2	138.0	152.8	232.1
1950	173.5	148.0	140.2	156.4	240.8
1951	187.4	155.0	145.4	162.4	267.1
1952	191.5	163.5	151.8	165.8	293.3
1953	193.0	169.2	155.9	171.2	311.7
1954	193.8	174.6	160.5	177.0	330.0
1955	193.2	178.6	166.1	178.7	345.8
1956	196.1	185.1	171.0	182.1	364.6
1957	202.9	192.5	178.4	186.6	393.8
1958	208.5	201.8	184.5	192.3	416.3
1959	210.1	210.5	190.8	197.1	439.6
1960	213.5	217.9	195.6	201.0	469.6
1961	215.7	224.4	200.6	201.9	505.4
1962	218.2	230.2	206.5	207.3	540.8
1963	220.9	235.9	211.1	213.2	575.0
1964	223.8	240.7	216.4	218.8	603.8
1965	227.5	246.6	224.2	225.7	638.8

SOURCE: U. S. DEPARTMENT OF LABOR, Bureau of Labor Statistics, Washington, D. C. 20212; October 1966.

Find your future in the HEALTH FIELD

. . . a career guide

"Find your future in the health field," urges a brochure published by the Wisconsin Health Council, Inc. The brochure, developed with the assistance of the State Medical Society, contains information on 26 careers in health.

The publication is unique in its presentation. It is intended to supplement existing careers materials, and gives factual and statistical information on personal qualifications, educational requirements and opportunities, and employment possibilities in each of the fields. It places emphasis on Wisconsin.

Copies are distributed to guidance counselors in every Wisconsin school, and individual copies are available from the Wisconsin Health Council to youngsters interested in health careers.

Supplies are also available to physicians who participate in career days in their local schools; they may be obtained by writing the State Medical Society, Box 1109, Madison 53701.

The Wisconsin Health Council, which published the brochure, was formed in 1948 to stimulate citizen interest in public health in Wisconsin.

Medicine, Stamps, and the History of Man

What do five signers of the Declaration of Independence, Rabbi Moshe Ben Maimonides, Aristotle and Goethe have in common? All were prominent physicians or made significant contributions to medical knowledge. They are among the hundreds of men and women whose achievements in medicine have been commemorated on postage stamps.

Joseph H. Kler, M.D., F.A.C.S. of New Brunswick, N.J., has written an unusual article which appeared in a recent issue of the Minkus Stamp Journal. In "Medicine, Stamps, and the History of Man," physicians will be amazed to discover how thoroughly the history of medicine has been recorded on stamps. Doctor Kler has compiled the world's finest collection of Medicine on Stamps. His article, which traces the evolution of medicine from the ancient Egyptians to the present, is illustrated with many stamps from his unique collection.

Doctor Kler's presentation of medicine *on* stamps suggests that there may be medicine *in* stamps as well. Franklin D. Roosevelt, the world's foremost collector, once said, "I owe my life to my hobbies, especially stamp collecting." The fact that stamp collectors find a sense of satisfaction and accomplishment in their hobby is well known. While the overwhelming majority of collectors are active individuals who turn to their hobby for the pleasure it provides, the therapeutic value inherent in philately should also receive consideration. The hobby is mentally absorbing and physically untaxing—benefits which can go a long way during a convalescent period. Harried physicians, too, with their demanding schedules, may find the relaxation and satisfaction of such a hobby especially rewarding and stimulating.

Because it is noiseless and unobtrusive, it is sometimes difficult to realize that stamp collecting claims more participants than any other hobby in the world. With so many millions of collectors about, physicians will find the quarterly Minkus Stamp Journal a welcome addition to the magazines in their waiting rooms.

Subscriptions, starting with the issue in which Doctor Kler's article appears, are available at $2.00 per year, $5.00 for 3 years, and $3.00 per year outside the U.S.A. Send to: Minkus Stamp Journal, 116 West 32nd St., New York, N.Y. 10001.

Stamp Collecting

AN EDUCATIONAL AND HEALTHFUL HOBBY

IT HAS BEEN truly said that "the postage stamps of a nation are a picture gallery of its glories. They depict in miniature its famous men, the great events of its history, its industries, its natural wonders."

Thus the Charitable, Educational and Scientific Foundation of the State Medical Society of Wisconsin was prevailed upon to become interested in the development of a collection of stamps related to medicine and allied fields. In part this is associated with an active interest on the part of the Foundation and the State Medical Society in the preservation of medical history and the presentation to physicians and the public of the story of medical progress. It also is a means of emphasizing the fact that "hobbies for health" are important to the overall well-being of the individual.

Some initial donations of medical stamps from throughout the world began the Society collection in 1958 and since that time physicians and others have seen fit to expand the collection to the point where there are more than 3,000 issues. These include first day covers, full sheets, blocks of four, and many other combinations known best to the philatelists.

Displays of this topical stamp collection are exhibited in the headquarters of the State Medical Society, which has many visitors, and at the Society's Museum of Medical Progress and Stovall Hall of Health at Prairie du Chien. They also are made available on a loan basis to other groups and individuals who have a legitimate interest in the display. In such displays each stamp or group of stamps is accompanied by a brief explanation of its medical and historical significance.

Although stamp collecting by an organization may be a bit unusual, its practical value appears to be of unlimited potentialities. On a number of occasions these displays of stamps have been utilized as part of a visual presentation in speaking engagements on the subject of medical history, public health education, careers in medical and allied fields and the like. On other occasions stamps from the collection have been used to illustrate brochures, certificates of merit and appreciation, and in many other ways.

The collection has been loaned to the University of British Columbia School of Medicine, Vancouver, Canada, to the West Bend Gallery of Fine Arts in Wisconsin, to several stamp clubs, business establishments, schools, and stamp exhibitions in the state.

The Society acquired a block of 25 Japanese stamps issued in 1958 commemorating the Fifth International Congress on Diseases of the Chest

and the Seventh International Congress of Bronchoesophagology. Others donated commemorate the Red Cross, passage of the Pure Food and Drug Law, Doctor Carver, and a Roumania issue in honor of Red Cross. A number of stamps were given the Society a number of years ago, including the cover: In Compliment 5th International Philatelic Exhibition 1956.

A special feature of the stamp displays is an entire series of malaria postage stamps, issued in 1962. These were issued by members of the United Nations to publicize the World Health Organization's fight against malaria. Malaria has long since disappeared from Wisconsin and most of the United States but in other countries of the world the job has barely begun. The global program for the eradication of malaria requires intensive worldwide informative and educational activities. The Foundation and the Society are assisting this educational effort through the display of these malaria postage stamps.

The Foundation at the request of a physician, and with his financial support, developed a display of U.S. aeronautic stamps. A display of proprietary medicinal tax stamps is being developed. A few physicians have donated their private collections to the Foundation. Others around the state are gradually being acquired.

The Society has been instrumental in the issuance of two commemorative stamps by the U.S. Postmaster's Department. In 1961 a stamp was issued commemorating the golden anniversary of the first Workmen's Compensation Law passed in Wisconsin. After five years of effort by the State Medical Society and with the cooperation of the American Medical Association, a traffic safety stamp was issued in 1965. The Society is currently working on a third commemorative stamp to honor Dr. William Beaumont.

The Foundation is actively seeking to expand this collection. The theme illustrates that only medicine has received international recognition through the postage stamps of all nations.

AMA Library Services Varied

THE MEDICAL LIBRARY at the AMA Headquarters in Chicago is comprised of an international collection of some 2,200 periodicals on basic medical science and clinical medicine and a comprehensive collection of pamphlets and reprints.

It offers free to members a periodical lending service and package library service.

AMA also "reads" hundreds of foreign medical journals for physicians, abstracting significant articles.

The Association maintains a Medical Film Library of more than 250 subjects and has the largest source file of medical films in the U.S.—more than 7,000 indexed references.

The AMA Department of Investigation has one of the largest collections of nostrums and quack gadgets and medicines in the U.S. and maintains the largest files existent on medical quackery.

AMA's Records Department keeps complete records on all licensed physicians. These information files are begun as soon as a student enters medical school and are kept for some years after a physician's death. These records are the most complete of any profession.

The Association also maintains an extensive library of legal briefs on medicolegal cases plus other medicolegal information and materials.

Each month the Archive-Library processes about 1,800 questions from members throughout the country on every phase of medicine—clinical, research, historical, and directory-type information regarding specialized associations and medical meetings.

Photo courtesy JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION

THE AMA MEDICAL LIBRARY is in use every day by physicians, researchers, science writers, educators, and others.

* * *

AT LEAST HALF the population of the United States will have some form of peridontal disease or be toothless because of it before they have passed the age of 45, the Veterans Administration research investigators estimate.

HEAVY PATIENT LOAD??

Then take a breather. Take the family on a Get-Away Weekend to Prairie du Chien, to the Museum of Medical Progress and Stovall Hall of Health. We open April 15 with 6,500 square feet of displays. Here are your heroes: hard-workinng prairie physicians, scientists. They gave you your heritage. We give you them *with drama and intimacy. You can lose a whole day here and wonder where the time went. Twenty thousand people did last year.*

And then what? Stroll around town in sneakers. Pick a good little restaurant for steak or fresh Mississippi catfish. Get a full *night's sleep in a clean, quiet motel. Drive up along the bluffs. Unwind. This is a lovely way to spend a weekend!*

The Museum of Medical Progress and Stovall Hall of Health

Prairie du Chien, Wisconsin

Owned and operated by the Charitable, Educational & Scientific Foundation of the State Medical Society of Wisconsin.

Controversies in Medicine

THEME FOR 1967 ANNUAL MEETING

STATE MEDICAL SOCIETY OF WISCONSIN

MAY 9–11

MILWAUKEE

JOHN K. CURTIS, M.D.
General Chairman

The Commission on Scientific Medicine is pleased to invite you to the 1967 Annual Meeting of the State Medical Society of Wisconsin, in Milwaukee, May 9 through 11, to take part in the many discussions which will be conducted around the general theme: Controversies in Medicine. Many subjects offer opportunities to review varying opinions on diagnosis and treatment, so the Commission has asked all component groups to plan programs in keeping with the general theme of the meeting.

We feel the 1967 Annual Meeting will be stimulating for all members and we hope you will plan your schedule so you can be in attendance. On the following pages you will find a complete schedule of the scientific program. Member physicians will receive a printed program in the mail in mid-April.

Sincerely,

John K. Curtis

JOHN K. CURTIS, M. D.
Chairman, Commission on Scientific Medicine

Timetable

NOTE: S–S: Sheraton–Schroeder Hotel

SUNDAY, MAY 7

Noon

12:00 Council Luncheon: East Room (5th Fl. S–S)

p.m.

2:00 Council Meeting: English Room (5th Fl. S–S)

6:00 Dinner: Councilors, Officers, Wives and Special Guests (New Members of "50 Year Club" and wives): East Room (5th Fl. S–S)

MONDAY, MAY 8

a.m.

8:00 Installation of Exhibits: Milwaukee Aud.

p.m.

4:00 Registration: House of Delegates: (5th Fl. Foyer S–S)

5:00 First Session: House of Delegates: Ballroom (5th Fl. S–S)

5:30 Auxiliary Board Meeting and Dinner: Loraine Room (S–S)

8:00 Buffet Supper and Entertainments: Delegates, Officers, Councilors and wives (Host: Schlitz Brewing Co.)

TUESDAY, MAY 9

a.m.

8:30 Registration and Opening of Exhibits: Milwaukee Aud.

9:00 Auxiliary: Registration and Coffee: Loraine Room (S–S)

9:00 Reference Committees: Parlors G, H, I, and Ballroom (S–S)

9:30 Auxiliary: Business Meeting: Loraine Room (S–S)

9:30 Scientific Programs: Milwaukee Aud.
"Shock"
"Thyroid Disease"

10:30 Pathology Board Meeting: Pine Room (5th Fl. S–S)

p.m.

12:00 Clinic Managers Luncheon: Milwaukee Athletic Club

12:30 Auxiliary Luncheon—Style Show: Milwaukee Athletic Club

12:30 Scientific Luncheons: 4th and 5th Fls. (S–S)

2:00 Scientific Program: Milwaukee Aud.
Internal Medicine
General Surgery
Pathology
Radiology

3:00 Wisconsin Academy of GP Board Meeting: English Room (5th Fl. S–S)

4:00 Nominating Committee: Room 504 (5th Fl. S–S)

6:00 Alumni Dinners
Mayo Clinic
Marquette
U. of W.

6:30 Radiology Dinner (Members only): Stoeffer's Restaurant

7:30 Second Session: House of Delegates: Ballroom (5th Fl. S–S)

WEDNESDAY, MAY 10

a.m.

8:30 Registration and Exhibits: Milwaukee Aud.

9:00 Auxiliary: Registration and Coffee: Loraine Room (S–S)

9:00 Third Session: House of Delegates: Ballroom (5th Fl. S–S)

9:30 Auxiliary: Business Meeting: Loraine Room (S–S)

9:30 Scientific Programs: Milwaukee Aud.
"Hormones in Women"
"Radioisotopes in Diagnosis"

10:00 Resident-Intern Program: Milwaukee Aud.

11:00 Council Meeting: Club Rooms (3rd Fl. S–S)

p.m.

12:30 Council Luncheon: Club Rooms (3rd Fl. S–S)

12:30 Scientific Luncheons (4th and 5th Fls. S–S)

1:00 Auxiliary Luncheon: Eugene's Restaurant

2:00 Scientific Programs: Milwaukee Aud.
"Cardiovascular Disease"
Obstetrics and Gynecology
Pediatrics
Psychiatry

6:30 President's Reception (For those Attending Dinner): East Room (5th Fl. S–S)

7:15 Annual Dinner and Dance: Ballroom (5th Fl. S–S)

THURSDAY, MAY 11

a.m.

8:30 "Wet Clinic", Wisconsin Surgical Society: St. Joseph's Hospital

9:30 Scientific Programs: Milwaukee Auditorium
Kidney Transplants
Care of the Dying

9:30 Ophthalmology Demonstrations and Exhibit: East Room (5th Fl. S–S)

10:00 Otolaryngology Scientific Program: Milwaukee Aud.

p.m.

12:30 Scientific Luncheons (4th and 5th Fls. S–S)

2:00 Scientific Programs: Milwaukee Aud.
Anesthesiology
Dermatology
Orthopedic Surgery
Surgery

2:00 Ophthalmology Scientific Program: East Room (5th Fl. S–S)

4:00 Otolaryngology Lecture: University Club

6:15 EENT Dinner: University Club

6:30 Orthopedic Society Dinner (Members only): Milwaukee Athletic Club

7:00 Wisconsin Surgical Society Dinner (Members only): University Club

IMPORTANT INFORMATION

★ **REGISTRATION:** Pick up your badge at the registration desk, inside of main entrance of Milwaukee Auditorium, Fifth and Kilbourn Street. The time Tuesday, 8:30 a.m.–4:30 p.m.; Wednesday, 8:30–4:00 p.m.; and Thursday, 8:30 a.m.–3:30 p.m. Admittance by badge only.

★ **CERTIFIED GUESTS:** Senior and junior medical students will be admitted on Wednesday and Thursday, May 10–11. Medical assistants and hospital personnel will be admitted on Thursday, May 11 *only after 11:00 a.m.* Interns and residents will be admitted without registration fee, any time during meeting, *if certified by hospital.* Members of the Wisconsin State Dental Society and out-of-state physicians who are members of their county and state medical societies will be admitted by membership cards.

★ **VA and M.D.'s IN MILITARY SERVICE:** *Members of the Veterans Administration must be members of the State Medical Society to be admitted.* Physicians in the armed services admitted by presenting certification of current military status.

★ **TELEPHONE SERVICE:** Registration Desk, Milwaukee Auditorium—271–9609. For Milwaukee MDs, Direct call through 273–7700, Ext. 200, and it will be relayed to a special phone near the main meeting hall at the Auditorium. For those at Luncheons: 5th Floor Foyer phone at Sheraton–Schroeder Hotel—271–7250. Tell your secretary the *room number of the luncheon, so we can locate you!* (Your ticket has this information)

★ **RESERVATIONS FOR NOON LUNCHEONS:** For Round Tables, at registration desk between 8:00 a.m. and 11:00 a.m., starting Tuesday, May 9. If any tickets remain unsold by 11:30 a.m. the day of the luncheon, they can be purchased in fifth floor foyer, Sheraton–Schroeder Hotel.

★ **RESERVATIONS FOR ANNUAL DINNER:** May be obtained at the registration desk in the Auditorium from 8:00 a.m. to 4:00 p.m. Tuesday and Wednesday. Attendance at the dinner Wednesday night by ticket only. Limit 500.

NOTIFY YOUR SECRETARY AND HOME

A special phone will be installed at the Registration Desk, Milwaukee Auditorium, through which you can be reached if you are attending the scientific programs.

THIS NUMBER IS: (Area Code 414)—271–9609

Times when you may be reached thru this phone:

Tuesday, May 9 and Wednesday, May 10: 8:30 a.m.-4:30 p.m.

Thursday, May 11: 8:30 a.m.–4:00 p.m.

TELL YOUR HOME AND SECRETARY WHERE YOU WILL BE SLEEPING, SO YOU CAN BE REACHED THERE AT OTHER TIMES WHEN YOU ARE IN MILWAUKEE.

JOHN K. CURTIS, MD
Chairman, Commission on Scientific Medicine

W. T. RUSSELL, MD
Program Chairman

ANNUAL MEETING PROGRAM

ARRANGEMENTS UNDER DIRECTION OF

Commission on Scientific Medicine

JOHN K. CURTIS, M.D. _____ Madison
Chairman

W. T. RUSSELL, M.D. _____ Sun Prairie
General Program Chairman

THOMAS V. GEPPERT, M.D. _____ Madisan
Scientific Exhibits

E. S. GORDON, M.D. _____ Madisan
OVID MEYER, M.D. _____ Madison
ALBERT MARTIN, M.D. _____ Milwaukee
R. A. STARR, M.D. _____ Viroqua
J. A. KILLINS, M.D. _____ Green Bay
A. V. PISCIOTTA, M.D. _____ Milwaukee
BEN R. LAWTON, M.D. _____ Marshfield

Ex officio:

GERALD A. KERRIGAN, M.D. _____ Milwaukee
Dean, Marquette University School of Medicine

PETER L. EICHMAN, M.D. _____ Madison
Dean, University of Wisconsin Medical School

V. S. FALK, JR., M.D. _____ Edgertan
Medical Editor, *The Wisconsin Medical Journal*

SUPPORT YOUR FOUNDATION

It is your opportunity to give financial assistance to the charitable, educational and scientific aspects of medicine as they relate to the health and well-being of the people of Wisconsin. All contributions to the Foundation are deductible for income tax purposes. Checks may be made out to: CES Foundation, and sent to CES Foundation, State Medical Society of Wisconsin, Box 1109, Madison, Wis. 53701.

House of Delegates

The House of Delegates meetings are regarded as among the most important functions of the Society. Reports of the officers and committees, as well as new business, will be presented at the initial session. Reference committees will meet Tuesday morning, with reports to be made at the Tuesday evening session. The Nominating Committee will meet Tuesday afternoon and the third session, with election of officers, will be held on Wednesday morning.

Society members are urged to participate in the discussions on reports, resolutions, and nominations in the open hearings of the reference committees.

SCHEDULE

MONDAY, MAY 8

p.m.

4:00 REGISTRATION for first session of House of Delegates, 5th Floor Foyer, Sheraton–Schroeder Hotel

5:00 FIRST SESSION, House of Delegates, Ballroom, 5th Floor, Sheraton–Schroeder Hotel

TUESDAY, MAY 9

a.m.

9:00 REFERENCE COMMITTEES: Parlors G, H, and I, and Ballroom: Sheraton–Schroeder Hotel

4:00 NOMINATING COMMITTEE: Room 504, 5th Floor, Sheraton–Schroeder Hotel

7:00 REGISTRATION for second session: 5th Fl. Foyer, Sheraton–Schroeder Hotel

7:30 SECOND SESSION, House of Delegates, Ballroom (5th Fl.)

WEDNESDAY, MAY 10

a.m.

9:00 THIRD SESSION: Ballroom (5th Fl.)

Woman's Auxiliary PROGRAM

MONDAY, MAY 8

P.M.

5:30 Pre-Convention Board Meeting and Dinner (Sheraton–Schroeder Hotel)

TUESDAY, MAY 9

A.M.

9:00 Registration and Coffee (Loraine Room, Sheraton–Schroeder Hotel)

9:30 First Business Session (Loraine Room, Sheraton–Schroeder Hotel)

P.M.

12:30 Luncheon (Milwaukee Athletic Club) Gimbels Style Show
Speaker: V. S. Falk, MD—"Experiences in Viet Nam"

WEDNESDAY, MAY 10

A.M.

9:00 Registration and Coffee (Loraine Room, Sheraton–Schroeder Hotel)

9:30 Second Business Session (Loraine Room, Sheraton–Schroeder Hotel)

P.M.

12:30 LUNCHEON (Eugene's) Fritzel Informal Style Show
Speaker: Patricia Lanier, MD—"Women in Action"
Guest of Honor: Mrs. Warren Knowles, Madison

6:30 President's Reception (all those attending Annual Dinner, State Medical Society) Sheraton–Schroeder Hotel

7:15 Dinner and Dance of State Medical Society Sheraton–Schroeder Hotel)

MUSEUM OF MEDICAL PROGRESS AND STOVALL HALL OF HEALTH

Prairie du Chien, Wis.

Opens April 15

See details on page 152 of this issue.

1967 ANNUAL MEETING PROGRAM

STATE MEDICAL SOCIETY OF WISCONSIN • MAY 9–11 • MILWAUKEE

TUESDAY, MAY 9

8:30—REGISTRATION AND VIEWING OF EXHIBITS

MORNING GENERAL SCIENTIFIC PROGRAMS

PLANKINTON HALL, MILWAUKEE AUDITORIUM

9:30—MEDICAL TREATMENT OF SHOCK

Moderator: RICHARD RIESELBACH, MD, Madison

Participants:

F. S. Simeone, MD, Cleveland
Professor of Surgery, Western Reserve University School of Medicine, and Cleveland Metropolitan General Hospital

Wesley Spink, MD, Minneapolis
Professor of Medicine, University of Minnesota Medical School

10:30—RECESS TO VIEW EXHIBITS

11:00—THE TREATMENT OF THYROID DISEASE

Moderator: WILLIAM ENGSTROM, MD, Milwaukee

Participants:

O. H. Beahrs, MD, Rochester
Professor of Surgery, Mayo Graduate School of Medicine

Robert C. Meade, MD, Milwaukee

Thomas F. Nikolai, MD, Marshfield

12:30—SCIENTIFIC LUNCHEONS

SHERATON–SCHROEDER HOTEL

INTERNAL MEDICINE

1. OBESITY AND DIABETES
E. S. Gordon, MD, Madison
Professor of Medicine, University of Wisconsin Medical School
PARLOR D: FOURTH FLOOR

2. IATROGENIC DISEASE
W. S. Middleton, MD, Madison
Dean Emeritus, University of Wisconsin Medical School; and Consultant to the Veterans Administration
PARLOR B: FOURTH FLOOR

3. CURRENT PROBLEMS IN ANTIBACTERIAL THERAPY
Wesley Spink, MD, Minneapolis
Chairman: Ovid O. Meyer, MD, Madison
EAST ROOM: FIFTH FLOOR

4. PREVENTION OF RHEUMATIC HEART DISEASE—MODERN METHODS
Jeremiah Stamler, MD, Chicago
Director, Heart Disease Control Program, Chicago Board of Health; Executive Director, Chicago Health Bureau Council; Associate Professor of Medicine, Northwestern University Medical School
Chairman: Dean Emanuel, MD, Marshfield
PARLOR A: FOURTH FLOOR

OBSTETRICS AND GYNECOLOGY

5. CURRENT METHODS OF INDUCING OVULATION
Richard Mattingly, MD, Milwaukee
Professor and Chairman, Department of Gynecology and Obstetrics, Marquette University School of Medicine
PARLOR F: FOURTH FLOOR

PATHOLOGY

6. VIRAL ETIOLOGY OF LEUKEMIA AND LYMPHOMAS
Ludwik Gross, MD, Bronx, N. Y.
Chief, Cancer Research Unit, Veterans Administration Hospital
Chairman: Philip G. Piper, MD, Madison
PERE MARQUETTE ROOM: FIFTH FLOOR

RADIOLOGY

7. TELOGNOSIS: CLOSED-SYSTEM TELECOMMUNICATIONS
J. Gershon–Cohen, MD, Philadelphia
Professor of Radiologic Research, Temple University School of Medicine
Chairman: Robert Feulner, MD, Waukesha
ENGLISH ROOM: FIFTH FLOOR

SURGERY

8. SURGICAL MANAGEMENT OF INFLAMMATORY DISEASE OF THE INTESTINAL TRACT
O. H. Beahrs, MD, Rochester
Chairman: Albert G. Martin, MD, Milwaukee
PARLOR C: FOURTH FLOOR

9. PRE- AND POSTOPERATIVE CARE OF THE SURGICAL PATIENT
F. S. Simeone, MD, Cleveland
Chairman: Edwin Ellison, MD, Milwaukee
PARLOR E: FOURTH FLOOR

TUESDAY—continued

AFTERNOON SCIENTIFIC PROGRAMS

1. *INTERNAL MEDICINE*

PLANKINTON HALL, MILWAUKEE AUDITORIUM

"The Treatment of Atherosclerosis"

Chairman: JOHN H. WISHART, MD, Eau Claire
President, Wisconsin Society of Internal Medicine

2:00—DIET AND OTHER FACTORS IN THE TREATMENT OF ATHEROSCLEROSIS
Jeremiah Stamler, MD, Chicago
(Elvehjem Memorial Lecture)

3:00—RECESS TO VIEW EXHIBITS

3:30—PANEL ON TREATMENT OF ATHEROSCLEROSIS

Moderator: E. S. GORDON, MD, Madison

Participants:

Jeremiah Stamler, MD, Chicago

Norman Engbring, MD, Milwaukee
Associate Professor of Medicine, Marquette University

William B. Parsons, Jr., MD, Madison
Department of Internal Medicine, Jackson Clinic

2. *GENERAL SURGERY*

NORTH KILBOURN HALL, MILWAUKEE AUDITORIUM

Chairman: JACK A. KILLINS, MD, Green Bay

2:00—SMALL BOWEL OBSTRUCTION
F. S. Simeone, MD, Cleveland
(William Beaumont Memorial Lecture)

2:30—LOW ANTERIOR RESECTION FOR TREATMENT OF CANCER OF THE COLON AND RECTUM
O. H. Beahrs, MD, Rochester

3:00—RECESS TO VIEW EXHIBITS

3:30—PANEL AND DISCUSSION ON LECTURES GIVEN

Moderator: JACK A. KILLINS, MD, Green Bay

Participants:

O. H. Beahrs, MD, Rochester

Adolph Gundersen, MD, La Crosse

Richard Lillie, MD, Milwaukee

F. S. Simeone, MD, Cleveland

3. *PATHOLOGY*

JUNEAU HALL, MILWAUKEE AUDITORIUM

"The Role of Viruses in the Genesis of Neoplasia"

Chairman: STANLEY L. INHORN, MD, Madison
Director, State Laboratory of Hygiene

2:00—ONCOGENIC VIRUSES
Ludwik Gross, MD, Bronx, N. Y.

2:30—THE BOVINE PAPILLOMA VIRUS
Carl Olson, DVS, PhD, Madison

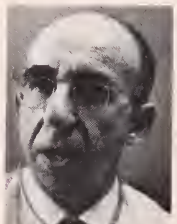
2:50—VARIETIES OF MOLECULAR DEFECTS IN CHEMICAL CARCINOGENESIS
Van R. Potter, PhD, Madison
Professor of Oncology, University of Wisconsin Medical School

3:10—RECESS TO VIEW EXHIBITS

3:40—PANEL OF PARTICIPANTS (with audience participation)
to 4:40 Discussion and questions on papers presented before recess period

MAKE YOUR ROOM RESERVATIONS

On page 17, following this program, you will note a form to use for a room reservation at the Sheraton–Schraeder Hotel, Milwaukee. *Do not delay in making your reservation.*


STAMLER

GROSS

GERSHON–COHEN

SIMEONE

BEAHRS

SPINK

TUESDAY—Afternoon Program, continued

4. *RADIOLOGY*

SOUTH KILBOURN HALL, MILWAUKEE AUDITORIUM

"Controversy in Radiology—Past and Present"

Chairman: HOWARD MAUTHE, MD, Fond du Lac
President, Wisconsin Radiological Society

2:00—MAMMOGRAPHY

J. Gershon-Cohen, MD, Philadelphia

2:40—DISCUSSION

3:00—RECESS TO VIEW EXHIBITS

3:30—PANEL ON "RADIOTHERAPY vs RADIOCHEMOTHERAPY"
to
4:30

Moderator: HOWARD MAUTHE, MD, Fond du Lac

Participants:

Robert J. Samp, MD, Madison
Frank F. Gollin, MD, Milwaukee
Joyce Kline Puletti, MD, Madison
John Mokrohisky, MD, Green Bay
Maurice Greenberg, MD, Milwaukee

4:30—BUSINESS MEETING, Wisconsin Radiological Society

6:30—DINNER, Wisconsin Radiological Society

STOEFFER'S RESTAURANT, Marine Plaza Bank Bldg.

Speaker: ROBERT J. SAMP, MD, Madison
"From the Outside Looking In"

$5.75 per person. Reservations to Harold F. Ibach, MD, 2400 W. Villard Ave., Milwaukee, Wis. 53209

SEWELL

WOLD

LUNCHEON RESERVATIONS

See page 166 for speakers and topics. *Attendance limited*, so select the luncheons you wish to attend, and make reservations *immediately*.

WEDNESDAY, MAY 10

MORNING GENERAL SCIENTIFIC PROGRAM

PLANKINTON HALL, MILWAUKEE AUDITORIUM

9:30—HORMONE THERAPY IN WOMEN . . . FOREVER?

Moderator: RAYMOND E. WHITSITT, MD, Madison
President, Wisconsin Society of Obstetrics and Gynecology

Participants:

Saul Gusberg, MD, New York City
Professor and Chairman of Obstetrics and Gynecology, Mt. Sinai School of Medicine

Ben M. Peckham, MD, Madison
Professor of Gynecology and Obstetrics, University of Wisconsin Medical School

10:30—RECESS TO VIEW EXHIBITS

11:00—PRESENT STATUS OF RADIOISOTOPES IN DIAGNOSIS

Chairman: NORMAN ENGBRING, MD, Milwaukee

John R. Cameron, PhD, Madison
Professor of Radiology, University of Wisconsin Medical School

11:45—DISCUSSION

Frank C. Larson, MD, Madison
Professor of Medicine, University of Wisconsin Medical School

NEW 50 YEAR CLUB MEMBERS

The following will be honored at a special dinner of the Councilors and Officers on Sunday, May 7, as new members of the 50 Year Club:

Clarence H. Boren, MD ..... *Marinette*
Roland S. Cron, MD ..... *Milwaukee*
Karl H. Doege, MD ..... *Marshfield*
Herman A. Heise, MD ..... *Milwaukee*
Leo A. Hoffmann, MD ..... *Campbellsport*
Timothy J. Howard, MD ..... *Milwaukee*
Michael Kasak, MD ..... *Milwaukee*
Sarkis H. Kash, MD ..... *Cudahy*
Edward F. Mielke, MD ..... *Appleton*
Russell A. Oldfield, MD ..... *Eagle River*
J. Arthur Riegel, MD ..... *St. Croix Falls*
B. H. Schlomovitz, MD ..... *Milwaukee*
Edmund A. W. Scholter, MD ..... *Milwaukee*
Albert R. Tormey, MD ..... *Madison*

ANNUAL DINNER

WEDNESDAY EVENING—MAY 10

As President of the State Medical Society I am anxious to make this Dinner in connection with our 126th Annual Meeting a happy occasion. Special recognition will be accorded several physicians, and we shall have as guests dignitaries from other medical societies and ancillary organizations.

But, primarily, this will be a *social occasion*, and I hope you and your wife will share it with us.

Sincerely,

F. E. Drew M.D.

Frank E. Drew, M.D.
President

PRESIDENT'S RECEPTION

6:30 P. M.

East Room: Sheraton–Schroeder Hotel

ANNUAL DINNER

7:15 P. M.

Ballroom: Sheraton–Schroeder Hotel

SPECIAL ENTERTAINMENT:

DANCING: The Ron Harvey Orchestra of Fond du Lac will provide music for dancing during the dinner and following the program.

$8.50 Per Person

MAKE RESERVATIONS BY MAIL OR AT REGISTRATION DESK BEFORE NOON, WEDNESDAY

WEDNESDAY—Morning Program, continued

MORNING SPECIAL PROGRAM

"Resident and Intern Papers"

JUNEAU HALL, MILWAUKEE AUDITORIUM

This is a competitive program with cash awards of $100 each for the two winning presentations. One award known as the W. S. MIDDLETON AWARD and the second as the HARRY BECKMAN AWARD

Chairman: JOHN K. CURTIS, MD, Madison
Chairman, Commission on Scientific Medicine

10:00—**DIFFERENTIAL BRONCHO-SPIROMETRY IN INTACT DOGS AND FOLLOWING UNILATERAL THORACOTOMY AND HILAR STRIPPING**
Jafar Shar-Mirany, MD, Milwaukee
Resident in Surgery, Marquette University School of Medicine

10:15—Discussant: WILSON WEISEL, MD, Milwaukee

10:20—**PREVENTION OF ESTROGEN-INDUCED GYNECOMASTIA BY EXTERNAL RADIATION**
Hans Wolf, MD, Madison
Resident in Surgery, Veterans Administration Hospital

10:35—Discussant: HALVOR VERMUND, MD, Madison

10:40—**BIO-ASSAY TECHNIQUE FOR DIAGNOSIS OF ULCEROGENIC TUMORS**
John Mathison, MD, Milwaukee
General Resident, Milwaukee County Hospital

10:55—Discussant: STUART D. WILSON, MD, Milwaukee

11:00—**HEPATIC ARTERY AND CELIAC AXIS INFUSION OF 5-FLUOROURACIL IN THE TREATMENT OF UPPER ABDOMINAL MALIGNANCIES**
Louis C. Bernhardt, MD, Madison
Resident in Surgery, University Hospitals

11:15—Discussant: ROBERT O. JOHNSON, MD, Madison

11:20—**EXPERIENCES WITH EX VIVO PERFUSION OF CADAVERIC HUMAN LIVERS**
James F. Romer, MD, Milwaukee
Resident in Surgery, Marquette University School of Medicine

11:35—Discussant: JOSEPH C. DARIN, MD, Milwaukee

11:40—**EXPERIMENTAL EVALUATION OF THE RENAL EFFECT OF DIFFERENT IRRIGATING FLUIDS IN TRANSURETHRAL PROSTATIC SURGERY**
Gholam Malek, MD, Madison
Resident in Surgery, Veterans Administration Hospital

11:55—Discussant: PAUL O. MADSEN, MD, Madison

WEDNESDAY—continued

12:30—SCIENTIFIC LUNCHEONS

SHERATON–SCHROEDER HOTEL

INTERNAL MEDICINE

1. **NEWER DRUGS AND THEIR USES**
   Ovid O. Meyer, MD, Madison
   Professor of Medicine, University of Wisconsin Medical School
   PARLOR E: FOURTH FLOOR

2. **MANAGEMENT OF ARRHTHYMIAS**
   Oglesby Paul, MD, Chicago
   Professor of Medicine, Northwestern University School of Medicine
   Chairman: John Huston, MD, Milwaukee
   EAST ROOM: FIFTH FLOOR

3. **MANAGEMENT OF ACUTE INSUFFIENCY DUE TO CHRONIC OBSTRUCTIVE LUNG DISEASE**
   Gordon L. Snider, MD, Milwaukee
   Professor of Medicine, Marquette University School of Medicine
   PARLOR C: FOURTH FLOOR

OBSTETRICS AND GYNECOLOGY

4. **SELECTION OF TREATMENT FOR UTERINE CANCER**
   Saul Gusberg, MD, New York City
   Chairman: Frederick J. Hofmeister, MD, Milwaukee
   ENGLISH ROOM: FIFTH FLOOR

5. **INDUCTION OF OVULATION WITH CLOMIPHENE AND PERGONAL**
   William Spellacy, MD, Minneapolis
   Assistant Professor of Obstetrics and Gynecology, University of Minnesota Medical School
   Chairman: Saul F. Schwartz, MD, Milwaukee
   PARLOR A: FOURTH FLOOR

PEDIATRICS (And Internal Medicine)

6. **WHITHER INFECTIONS?**
   Mark H. Lepper, MD, Chicago
   Professor of Preventive Medicine, University of Illinois at The Medical Center; and Executive Vice President, Professional and Academic Affairs, Presbyterian St. Luke's Hospital
   Chairman: Rex Ruppa, MD, Milwaukee
   PARLOR B: FOURTH FLOOR

PSYCHIATRY

7. **THE EVALUATION AND MANAGEMENT OF SUICIDAL PATIENTS**
   Carl Wold, PhD, Los Angeles
   Chief Psychologist, Suicide Prevention Center
   Chairman: Paul G. Stein, MD, Milwaukee
   PERE MARQUETTE ROOM: FIFTH FLOOR

RADIOLOGY

8. **HAZARDS OF RADIATION**
   John R. Cameron, PhD, Madison
   Chairman: Norman Engbring, MD, Mliwaukee
   PARLOR H: FOURTH FLOOR

SURGERY

9. **THE CAUSE AND PREVENTION OF MYOCARDIAL INFARCTION**
   William H. Sewell, MD, Sayre, Pa.
   Chief of Cardiac Surgery, Guthrie Clinic
   Chairman: W. Dudley Jahnson, MD, Milwaukee
   PARLOR D: FOURTH FLOOR

AFTERNOON SCIENTIFIC PROGRAMS

1. *CARDIOVASCULAR DISEASES*
   Sponsor: WISCONSIN HEART ASSOCIATION
   PLANKINTON HALL, MILWAUKEE AUDITORIUM

2:00—MEDICAL AND SURGICAL MANAGEMENT OF CORONARY ARTERY DISEASE
Moderator: JOHN HUSTON, MD, Milwaukee
Participants:
William H. Sewell, MD, Sayre, Pa.
Oglesby Paul, MD, Chicago

3:00—RECESS TO VIEW EXHIBITS

3:30—GRADED EXERCISES IN THE MANAGEMENT OF CORONARY ARTERY DISEASE
Moderatar: DEAN EMANUEL, MD, Marshfield
Participants:
Oglesby Paul, MD, Chicago
Bruno Balke, MD, Madison
Professor of Physiology, University of Wisconsin Medical School

GUSBERG

SPELLACY

LEPPER

ANNUAL PHOTOGRAPHY EXHIBIT

Beautiful and exciting pictures taken by physicians. Awards will be made befare the Annual Meeting.

2. *OBSTETRICS AND GYNECOLOGY*

NORTH KILBOURN HALL, MILWAUKEE AUDITORIUM

Chairman: RAYMOND E. WHITSITT, MD, Madison
President, Wisconsin Society of Obstetrics & Gynecology

2:00—DIABETES MELLITUS AND PREGNANCY: MANAGEMENT AND CURRENT RESEARCH
William N. Spellacy, MD, Minneapolis

2:45—DISCUSSION

3:00—RECESS TO VIEW EXHIBITS

3:30—ENDOCRINE CASE STUDIES

Discussants:
Saul Gusberg, MD, New York City
William Spellacy, MD, Minneapolis
Ben M. Peckham, MD, Madison
Richard Mattingly, MD, Milwaukee
Eleanor Delfs, MD, Milwaukee

3. *PEDIATRICS*

SOUTH KILBOURN HALL, MILWAUKEE AUDITORIUM

"When Should Antibiotics Be Withheld?"

Chairman: STEWART L. GRIGGS, MD, Green Bay
President, Wisconsin Chapter, American Academy of Pediatrics

2:00—*Mark H. Lepper, MD,* Chicago

2:10—*Burton A. Waisbren, MD,* Milwaukee
Associate Clinical Professor of Medicine, Marquette University School of Medicine

2:40—DISCUSSION

3:05—RECESS TO VIEW EXHIBITS

3:35—PREMATURE DEATHS ("Probably Preventable")

Case histories of two premature infants who developed serious problems during the course of their premature care which resulted in permanent disability. Both problems were ruled probably preventable at perinatal morbidity conferences.

Case 1—Humidity: Enough But Not Too Much
Richard Stiehm, MD, Madison
Assistant Professor of Pediatrics, University of Wisconsin Medical School

Case 2—Early Sugar vs Starvation
Stanley Graven, MD, Madison
Postdoctoral Fellow of Pediatrics, St. Mary's Hospital

4. *PSYCHIATRY*

JUNEAU HALL, MILWAUKEE AUDITORIUM

"Social and Medical Responsibility in Suicide"

Chairman: CHARLES LANDIS, MD, Milwaukee

2:00—*Carl Wold, PhD,* Los Angeles

3:00—RECESS TO VIEW EXHIBITS

3:30—PANEL ON TOPIC OF MEETING

Moderator: CHARLES LANDIS, MD, Milwaukee

Participants:
Gordon Johnsen, Madison
Administrator, Madison General Hospital
John Kluwin, Milwaukee
Legal Counsel, State Medical Society of Wisconsin
A. A. Lorenz, MD, Eau Claire
Carl Wold, PhD, Los Angeles

McCLEAVE

PERRY

NAKAMOTO

BLATT

BUCKLEY

JACKSON

RHOADS

ZIMMERMAN

ECKENHOFF

ANNUAL MEDICAL ART SALON

An Auxiliary-sponsored event which is always a highlight of Annual Meeting exhibits.

THURSDAY, MAY 11

MORNING SCIENTIFIC PROGRAMS

8:30—SPECIAL SURGICAL WET CLINIC

ST. JOSEPH'S HOSPITAL

This is a part of the program of the Wisconsin Surgical Society and nonmember guests are welcome.

9:30—KIDNEY DISEASE: TRANSPLANTS vs DIALYSIS

PLANKINTON HALL, MILWAUKEE AUDITORIUM

Moderator: EDWARD LENNON, MD, Milwaukee

Participants:

Satoru Nakamoto, MD, Cleveland
Staff Member, Department of Artificial Organs, Cleveland Clinic

Robert Burns, MD, Madison
Staff Member, Veterans Administration Hospital

9:30 to 12:00—SPECIAL PROGRAM ON OPHTHALMOLOGY

EAST ROOM: SHERATON–SCHROEDER HOTEL

1. *DEMONSTRATION AND INSTRUCTION* on the use of the Goldmann applanation tonometer with the Haag Streit slit lamp and the A–O slit lamp with their new applanation tonometer

Demonstrators:

John Hitz, MD, Milwaukee
Clinical Professor of Ophthalmology, Marquette University School of Medicine

George Sparks, MD, Madison
Division of Preventable Diseases, Wisconsin State Board of Health

Eliesor B. Suson, MD, Milwaukee
Assistant Professor of Ophthalmology, Marquette University School of Medicine

L. L. Garner, MD, Milwaukee
Assistant Clinical Professor of Ophthalmology, Marquette University School of Medicine

2. *EXHIBIT AND INSTRUCTION* on corneal pathology

Harry Easom, MD, Milwaukee
Assistant Clinical Professor of Ophthalmology, Marquette University School of Medicine

Richard O. Schultz, MD, Milwaukee
Associate Professor and Chairman, Department of Ophthalmology, Marquette University School of Medicine

NOTE: See pages 164 and 165 for details on scientific luncheon and afternoon program for Ophthalmologists

10:30—RECESS TO VIEW EXHIBITS

11:00—CARE OF THE DYING

Moderator: GEORGE E. COLLENTINE, JR., MD, Milwaukee

Participants:

Rev. Dr. Paul McCleave, Chicago
Director, Department of Medicine and Religion, American Medical Association

Paul S. Rhoads, MD, Chicago
Professor of Medicine (Emeritus), Northwestern University Medical School

Rabbi Manfred Swarsensky, Madison

SPECIAL PROGRAM ON OTOLARYNGOLOGY

JUNEAU HALL, MILWAUKEE AUDITORIUM

Chairman: P. A. SCIARRA, MD, Sheboygan

10:00—THE UBIQUITOUS TONSILLECTOMY

Moderator: MAXINE BENNETT, MD, Madison

Participants:

Charles Lobeck, MD, Madison
Professor of Pediatrics, University of Wisconsin Medical School

P. J. Noonan, MD, Milwaukee
Clinical Instructor in Otolaryngology, Marquette University School of Medicine

F. J. Vlazny, MD, Milwaukee
Instructor in Anesthesiology, Marquette University School of Medicine

11:00—SURGERY FOR BELL'S PALSY?

Moderator: HENRY WILLIAMS, MD, Minneapolis
Professor of Otolaryngology, The Medical School, University of Minnesota; and Chief of Otolaryngology Service, U.S. Veterans Administration Hospital

Participants:

Irving Blatt, MD, New Orleans
Professor and Head, Department of Otorhinolaryngology, Louisiana State University School of Medicine

Sanford Larson, MD, Milwaukee
Associate Professor and Chairman of the Department of Neurosurgery, Marquette University School of Medicine

Henry Peters, MD, Madison
Associate Professor of Neurology, University of Wisconsin Medical School

NOTE: At 4:00 pm, Doctor Blatt will present a lecture at the University Club, Milwaukee.

Dinner with Section on Ophthalmology, University Club, 6:15 pm. Speaker: LORENZ ZIMMERMAN, MD, Washington, D. C.

THURSDAY—continued

12:30—SCIENTIFIC LUNCHEONS

SHERATON–SCHROEDER HOTEL

ANESTHESIOLOGY

1. **NEW TRENDS IN MANAGEMENT OF CARDIAC ARRHYTHMIAS DURING ANESTHESIA**
   Joseph Buckley, MD, Minneapolis
   Professor of Anesthesiology, University of Minnesota Medical School
   Chairman: Frederick Cook, MD, Green Bay
   PARLOR B: FOURTH FLOOR

2. **ANESTHETIC ALARMISTS**
   James E. Eckenhoff, MD, Chicago
   Professor and Chairman of Anesthesia, Northwestern University Medical School
   Chairman: Robert O. Bjurstrom, MD, Eau Claire
   PARLOR C: FOURTH FLOOR

DERMATOLOGY

3. **ANTIBIOTICS IN DERMATOLOGY**
   Harold Perry, MD, Rochester
   Consultant in Dermatology, Mayo Clinic; Associate Professor of Dermatology, Mayo Graduate School of Medicine, University of Minnesota
   Chairman: Garrett Cooper, MD, Madison
   PARLOR F: FOURTH FLOOR

INTERNAL MEDICINE

4. **HOME DIALYSIS WITH A MAKE-IT-YOURSELF ARTIFICIAL KIDNEY**
   Satoru Nakamoto, MD, Cleveland
   Chairman: James Means, MD, Milwaukee
   PARLOR A: FOURTH FLOOR

5. **MODERN CONCEPTS OF PYELONEPHRITIS**
   Paul Rhoads, MD, Chicago
   Chairman. BRUNO J. PETERS, MD, Milwaukee
   PARLOR D: FOURTH FLOOR

OPHTHALMOLOGY

6. **EYE SECTION LUNCH AND BUSINESS MEETING**
   EAST ROOM: FIFTH FLOOR

ORTHOPEDIC SURGERY

7. **JOINT INJURIES**
   Ruth Jackson, MD, Dallas
   Assistant Clinical Professor of Orthopedic Surgery, University of Texas Southwestern Medical School
   Chairman: Charles Christensan, MD, Racine
   ENGLISH ROOM: FIFTH FLOOR

OTOLARYNGOLOGY

8. **CHRONIC RHINOSINUSITIS AND ITS RELATION TO DISEASE OF THE LOWER RESPIRATORY TRACT**
   Henry Williams, MD, Chicago
   Chairman: P. A. Sciarra, MD, Sheboygan
   PARLOR E: FOURTH FLOOR

AFTERNOON SPECIALTY SCIENTIFIC PROGRAMS

1. *ANESTHESIOLOGY*
   NORTH KILBOURN HALL, MILWAUKEE AUDITORIUM
   Chairman: ROBERT O. BJURSTROM, MD, Eau Claire
   President, Wisconsin Society of Anesthesiologists

   2:00—WHY USE ANY AGENT OTHER THAN NITROUS OXIDE AND HALOTHANE?
   Joseph Buckley, MD, Minneapolis
   Discussants:
   James E. Eckenhoff, MD, Chicago
   David J. Noll, MD, Madison

   3:00—RECESS TO VIEW EXHIBITS

   3:30—SHOULD VASOPRESSORS BE DISCARDED?
   James E. Eckenhoff, MD, Chicago
   Discussants:
   Joseph Buckley, MD, Minneapolis
   Sherwood W. Gorens, MD, Milwaukee

   4:30—BUSINESS MEETING, Section on Anesthesiology

2. *DERMATOLOGY*
   SOUTH KILBOURN HALL, MILWAUKEE AUDITORIUM
   Chairman: GERALD O. STUBENRAUCH, MD, Milwaukee
   President, Wisconsin Dermatological Society

   2:00—PROBLEM CASES
   Members of the Wisconsin Dermatological Society will present cases for discussion. HAROLD PERRY, MD, Rochester, Minn., will participate in the discussion

   3:00—RECESS TO VIEW EXHIBITS

   3:30—PEMPHIGUS, PEMPHIGOID OR DERMATITIS HERPETIFORMES?
   Harold Perry, MD, Rochester

SCIENTIFIC AND TECHNICAL EXHIBITS

Be sure to visit the many exhibits located in the Milwaukee Auditorium. Your interest contributes to the success of the Annual Meeting.

3. *OPHTHALMOLOGY*

EAST ROOM, SHERATON–SCHROEDER HOTEL

(See page 163 for the morning program on Ophthalmology)

The scientific program will follow the luncheon and business meeting which will be held in the East Room, Fifth Floor of the Sheraton–Schroeder Hotel. All Ophthalmologists are urged to attend the luncheon, and take part in the business meeting.

Chairman: JAMES V. BOLGER, MD, Waukesha

2:00—OCULAR PATHOLOGY IN THE CONGENITAL RUBELLA SYNDROME

Lorenz Zimmerman, MD, Washington, D. C.
Chief, Ophthalmic Pathology Branch, Armed Forces Institute of Pathology

3:00 to 4:00—THE CLINICAL APPLICATION OF TONOGRAPHY (Panel)

Moderator: JOHN HITZ, MD, Milwaukee

Participants:

Rodney J. Sturm, MD, Madison
Clinical Instructor, Department of Surgery, University of Wisconsin Medical School

L. L. Garner, MD, Milwaukee
Assistant Clinical Professor of Ophthalmology, Marquette University School of Medicine

G. R. Keskey, MD, Milwaukee
Clinical Instructor in Ophthalmology, Marquette University School of Medicine

NOTE: Following the scientific program, those Ophthalmologists in attendance are invited to attend the dinner of the Milwaukee Ophthalmological Society at 6:15 pm, University Club

Speaker: LORENZ ZIMMERMAN, MD, Washington, D. C.

Topic: *"Errors in the Diagnosis of Malignant Melanoma of the Choroid and Ciliary Body"*

Also, Doctor Zimmerman will conduct a CPC (as Visiting Professor at Marquette University), Friday, May 12, 9 to 11 am, in the King Conference Room, Milwaukee County Hospital. All MDs are invited.

4. *ORTHOPEDIC SURGERY*

JUNEAU HALL, MILWAUKEE AUDITORIUM

Chairman: CHARLES W. CHRISTENSON, MD, Racine

President, Wisconsin Orthopedic Society

2:00—CERVICAL STRAIN

Ruth Jackson, MD, Dallas

3:00—RECESS TO VIEW EXHIBITS

3:30—PANEL ON "CERVICAL STRAIN"

Moderator: HERMAN W. WIRKA, MD, Madison

Participants:

Ruth Jackson, MD, Dallas

Charles J. Frankel, MD, Charlottesville
Associate Professor of Orthopedic Surgery and Instructor in Medical Law, University of Virginia

John Linster, Wausau
Vice President, Employers Insurance Company

6:30—DINNER, Wisconsin Orthopedic Society

MILWAUKEE ATHLETIC CLUB. Members only

Speaker: CHARLES J. FRANKEL, MD, Charlottesville

Topic: *"The Orthopedist and the Law"*

5. *SURGERY*

PLANKINTON HALL, MILWAUKEE AUDITORIUM

Chairman: RUSSELL P. SINAIKO, MD, Madison
President, Wisconsin Surgical Society

2:00—CONTROVERSIAL ASPECTS OF MYOCARDIAL REVASCULARIZATION

William H. Sewell, MD, Sayre, Pa.
Guthrie Clinic

Randolph M. Ferlic, MD, Minneapolis
United States Public Health Cardiovascular Trainee

3:15—RECESS TO VIEW EXHIBITS

3:35—CONTROVERSIAL SURGERY

Case Presentations to a Panel of Argumentive Surgeons

Thomas J. Beno, MD, Green Bay

Richard J. Botham, MD, Madison

George B. Murphy, Jr., MD, La Crosse

Leonard W. Worman, MD, Milwaukee

4:30—PRESIDENTIAL ADDRESS

Albert G. Martin, MD, Milwaukee

5:00—BUSINESS MEETING, Wisconsin Surgical Society

6:30—DINNER PROGRAM, Wisconsin Surgical Society

Members and guests only. Vietnam Pot Pourri: VICTOR S. FALK, MD, Edgerton; SAMUEL B. HARPER, MD, Madison; ANTHONY R. CURRERI, MD, Madison; and WILLIAM G. GALLAGHER, MD, La Crosse

RESERVATION FORMS FOR

Noon Luncheons • Annual Dinner

NOTE: Attendance Limited! Please List 2 Choices for each of the days you make reservations. List in order of preference. $3.00 per luncheon, including gratuities and taxes.

TUESDAY, MAY 9 (See page 157 for listing)

LIST *TWO CHOICES* IN ORDER OF PREFERENCE

1. GORDON: Obesity and Diabetes
2. MIDDLETON: Iatrogenic Disease
3. SPINK: Current Problems in Antibacterial Therapy
4. STAMLER: Prevention of Rheumatic Heart Disease—Modern Methods
5. MATTINGLY: Current Methods of Inducing Ovulation
6. GROSS: Viral Etiology of Leukemia and Lymphomas
7. GERSHON–COHEN: Telognosis: Closed-System Telecommunications
8. BEAHRS: Surgical Management of Inflammatory Disease of the Intestinal Tract
9. SIMEONE: Pre- and Postoperative Care of the Surgical Patient

Name of Leader — *Name of Leader*

First Choice: _____ Second Choice: _____

WEDNESDAY, MAY 10 (See page 161 for listing)

LIST *TWO CHOICES* IN ORDER OF PREFERENCE

1. MEYER: Newer Drugs and Their Uses
2. PAUL: Management of Arrhythmias
3. SNIDER: Management of Acute Insufficiency Due to Chronic Obstructive Lung Disease
4. GUSBERG: Selection of Treatment for Uterine Cancer
5. SPELLACY: Induction of Ovulation with Clomiphene and Pergonal
6. LEPPER: Whither Infections?
7. WOLD: The Evaluation and Management of Suicidal Patients
8. CAMERON: Hazards of Radiation
9. SEWELL: The Cause and Prevention of Myocardial Infarction

Name of Leader — *Name of Leader*

First Choice: _____ Second Choice: _____

THURSDAY, MAY 11 (See page 164 for listing)

LIST *TWO CHOICES* IN ORDER OF PREFERENCE

1. BUCKLEY: New Trends in Management of Cardiac Arrhythmias During Anesthesia
2. ECKENHOFF: Anesthetic Alarmists
3. PERRY: Antibiotics in Dermatology
4. NAKAMOTO: Home Dialysis with a Make-It-Yourself Artificial Kidney
5. RHOADS: Modern Concepts in Pyelonephritis
6. EYE SECTION lunch and business meeting
7. JACKSON: Joint Injuries
8. WILLIAMS: Chronic Rhinosinusitis and Its Relation to Disease of the Lower Respiratory Tract

Name of Leader — *Name of Leader*

First Choice: _____ Second Choice: _____

ANNUAL DINNER, Wed., May 10

DANCING—COCKTAILS
SHORT SPEECHES—

$8.50 PER PERSON
(Including Gratuities and Taxes)

Number Luncheon Tickets ($3.00 each) . . . . _____ for $_____

Number Annual Dinner Tickets ($8.50 each) . . _____ for $_____ TOTAL $_____

Make Check Payable to: STATE MEDICAL SOCIETY OF WISCONSIN

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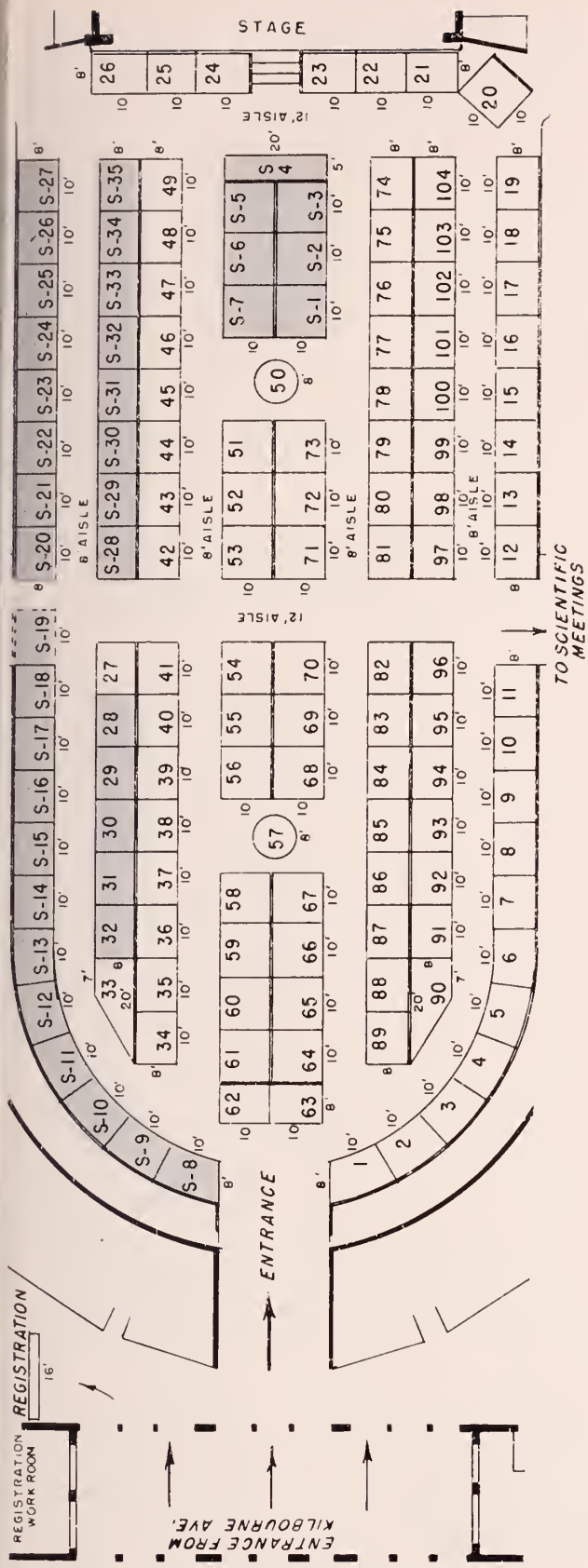

Scientific Exhibits

MILWAUKEE AUDITORIUM

EXHIBIT HOURS

Tuesday, May 9 ..... 8:30 a.m.–5:00 p.m.
Wednesday, May 10 ..... 8:30 a.m.–5:00 p.m.
Thursday, May 11 ..... 8:30 a.m.–3:45 p.m.
(Exhibits "break up" at 3:45 p.m. on Thursday, May 11)

THIS GROUP IN AREA S-1 THROUGH S-7 ON CHART

CRYOSURGERY OF THE PROSTATE

ROBERT A. HAIGHT, MD, NELSON A. MOFFAT, MD and CHARLES R. FRIEND, MD, Marshfield Clinic Foundation and Marshfield Clinic, Marshfield

The Cryosurgery Department of the Marshfield Clinic has accumulated a series of 40 high-risk patients who had their prostates removed by cryosurgery. The results of this series will be presented. Pictures showing the technique will also be shown and the cryosurgical instrument will be placed on exhibit and will be available for inspection. In this series of 40 high-risk patients, all of whom were over age 80, there were no deaths related directly to the procedure. Most of the patients are well with good urinary function.

EVALUATION OF ANALGESICS AND A NEW EPISIOTOMY PROCEDURE IN RELIEF OF POSTPARTUM PAIN AND TRAUMA

J. MORTON SCHNEIDER, MD, RALPH C. BENSON, MD and RAPHAEL B. DURFEE, MD, in cooperation with the University of Oregon Medical School

This exhibit shows the authors report on 295 patients, including 213 primagravidas, who required a vaginoperineotomy in the second stage of labor. This procedure was repeated on 11 of these patients when they returned as secundagravidas. A new median episiotomy technique, vaginoperineotomy, developed with the primary aim of decreasing the unnecessarily high incidence of symptomatic rectocele, is described with illustrations and photographs. The advantages, including the very low incidence of third degree laceration and possible disadvantages associated with the described vaginoperineotomy technique presented. A double-blind study of relief of pain and cramps in 215 postepisiotomy patients is also presented, in which the radomized administration of a muscle relaxant combined with acetophenetidin, caffeine and codeine, is compared with an analgesic as well as placebo.

EXTRACORPOREAL HEPATIC SUPPORT SYSTEM

JOSEPH C. DARIN, MD, Division of Surgery, Marquette University School of Medicine, Milwaukee

The treatment of hepatic failure remains unsatisfactory. We have studied a new modality of treatment which involves the perfusion of a cadaveric human liver. We

are the first group in this country to utilize this method of therapy. The exhibit will depict our initial efforts in the laboratory animal and in the human. It will include visual aids, and the actual machinery of extracorporeal liver perfusion will be demonstrated utilizing a model. Strip films of successful perfusions will be shown.

UROKINASE IN THE TREATMENT OF ACUTE PULMONARY THROMBOEMBOLISM

RICHARD D. SAUTTER, MD, DEAN A. EMANUEL, MD, FREDERICK J. WENZEL and JOHN I. MATSON, Marsheld Clinic Foundation and Marshfield Clinic, Marshfield

Ten patients with acute pulmonary thromboembolism of varying magnitudes have been treated with urokinase. This drug is an enzymatic fibrinolytic activator, a normal constituent of human urine. It has been known to produce in vivo and in vitro fibrinolysis. In this study of ten cases, it was judged to have excellent clinical results. The patients were also evaluated by serial pulmonary arteriography. In each case, resolution of the embolus was demonstrated. It appears that this drug greatly hastens the clinic process in acute pulmonary thromboemboli, and because of the extremely high mortality of pulmonary embolectomy, this may be the treatment of choice. The exhibit will display the serial pulmonary arteriogram, laboratory results, pulmonary artery pressure, and recommendation will be made as to the use of this drug.

GOLD FOIL IN THE TREATMENT OF CUTANEOUS ULCERS

WILLIAM F. SCHORR, MD and FREDERICK J. WENZEL, Marshfield Clinic Foundation and Marshfield Clinic, Marshfield

The exhibit will illustrate the method of treatment of cutaneous ulcers with gold foil. Color photographs of symmetrical ulcers treated with gold foil and other forms of therapy will be shown. An up-to-date summary of the results of gold foil therapy will also be given. The preliminary work on this type of therapy at our institution was presented in the WISCONSIN MEDICAL JOURNAL, November 1966, and has received a great number of reprint requests.

THIS GROUP IN AREA S-8 THROUGH S-19 ON CHART

TUBERCULIN TESTING—COMPARATIVE VALUES

WISCONSIN ANTI-TUBERCULOSIS ASSOCIATION

It is intended to present a comparison of the Tine, Sterneedle and Mantoux methods of tuberculin testing—of which none in the past has been found ideal. The exhibit will contain graphic and mechanical representations of the tuberculin tests and survery (Wisconsin) findings.

PKU SCIENTIFIC EXHIBIT

WISCONSIN STATE BOARD OF HEALTH

This exhibit will show the role of the attending physician in the detection of PKU patients utilizing the approved hospital laboratories for screening tests of newborn infants, referral clinics for confirmation tests and diagnosis, and the public health nurses and nutritionists for management of the PKU patient and his family. Studies made from hospital laboratory reports will show PKU statistics for 1966, the first year the PKU mandatory testing law has been in effect. PKU literature will be available to hand out.

VENEREAL DISEASE—SYPHILIS ERADICATION

MILWAUKEE HEALTH DEPARTMENT IN COOPERATION WITH THE STATE BOARD OF HEALTH AND PUBLIC HEALTH SERVICE

The exhibit has clinical plates of syphilitic lesions—spread charts showing chains of infection among youngsters. Resumes of the clinical course of syphilis. The exhibit encourages private physicians to participate in the national syphilis eradication effort by reporting all cases of syphilis promptly.

GASTRIC PHOTOGRAPHY WITH THE COLD LIGHT FIBERSCOPE

HARRY J. KANIN, MD, West Allis Memorial Hospital

Color photographs of the interior of the stomach were taken through the new (cold light) fiberscope. The brilliant illumination of this new instrument makes it possible to take color photographs of excellent quality. Enlarged color transparencies illustrating the normal stomach, normal pylorus, scarred gastric carcinoma are shown. The usefulness of the photographs in documenting gastroscopic observations is demonstrated. Photographs were taken with a thirty-five millimeter, single lens, reflex camera. The ready availability of this type of equipment, and the simplicity of technique, makes this procedure practical for any hospital.

RENIN—ANGIOTENSIN-BIO-ASSAY AND CLINICAL APPLICATION

J. R. CAFARO, MD, R. F. HEARN, MD, H. L. RIPPLE, MD, and ROCKLYN MORRIS, LARRY FISHER, St. Joseph's Hospital, Milwaukee

The ability to assay for renin-angiotension and measure the aldosterone levels in the circulation and urine are valuable diagnostic aids in the evaluation of patients with hypertension as well as of potential therapeutic and research significance in other disease states, such as cirrhosis, congestive failure, and nephritis. The purpose of this exhibit is to graphically demonstrate the mechan-

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isms involved in the renin-angiotensin system and the relationship which exists with the levels of aldosterone secretion and excretion, to portray the bio-assay method used at St. Joseph's Hospital and give report of clinical material in regard to the bio-assay procedure for angiotensin levels.

BACKFLOW IN EXCRETORY UROGRAPHY

G. W. SENGPIEL, MD, J. R. WEPFER, MD, A. E. FITZ, MD, J. F. HOLL, MD, R. C. OLSON, MD, R. A. KESSLER, MD, and J. P. MATSIS, MD, St. Joseph's Hospital, Milwaukee

Extravasation of contrast material from the renal collecting system of the kidney during retrograde pyelography has been thoroughly described. Escape of contrast medium from the pelvis and calcyes into the surrounding structure during intravenous pyelography is less well known although during the past few years considerable literature has accumulated on the subject. The phenomenon is now being recognized quite regularly by many observers. It is our purpose to demonstrate various types of backflow and to illustrate the mechanism by which they occur.

AMINOCENTESIS AND INTRAUTERINE TRANSFUSION

J. A. KLIEGER, MD, J. P. BECK, MD, E. J. BUERGER, MD, E. C. PARKER, MD, M. J. POPP, MD and W. C. STEWART, MD, St. Joseph's Hospital, Milwaukee

This exhibit will attempt to show graphically the management of the severely sensitized Rh negative pregnant female. The indications, complications and technique for aminocentesis will be detailed by means of colored Kodachrome slides and appropriate legends. The same will apply for intrauterine transfusion. Colored drawings indicating equipment, technique, etc., will be portrayed. If arrangements can be made, the exhibit will have an audio tape comment.

ELECTRONIC RHINOMANOMETRY

IRWIN E. GAYNON, MD, St. Michael's Hospital, Milwaukee

Electronic rhinomanometry is an objective manometric method of measuring continuous intranasal pressures. When a nozzle is placed, without impingement or distortion of the opposite nostril, realistic graphs are obtained with a transducer and electronic recorder. A recorded curve of a single breath may be divided into five parts and these will be described. Graphs illustrating the normal and the abnormalities of the upper respiratory tract will be given. Electronic objective rhinometric measurements for the evaluation of allergic, medical and surgical therapy of the nose is as important as examination or photographs.

ARTERIAL RECONSTRUCTION FOR LIMB SALVAGE

VICTOR M. BERNHARD, MD, RICHARD RODGERS, MD, KENNETH KAYSER, BEE, MS, and JOSEPH GUTIERREZ, MD, Marquette University School of Medicine and Milwaukee County General Hospital, Milwaukee

Many severely ischemic limbs destined to amputation may be rehabilitated by appropriate arterial reconstruction. In aged patients, restoration of the lower extremity to a state of comfortable usefulness is frequently the keystone of their declining years. This exhibit illustrates the problem of near end-stage lower extremity ischemia, correlated with arterial pathology as defined by arteriography. The techniques for restoration of sufficient arterial flow by grafting procedures to permit viability and function are depicted for aorto-iliac femoral–popliteal, and popliteal–tibial occlusive disease. Techniques for preoperative evaluation and criteria for operation are outlined. Hemodynamic studies illustrating the improvement in arterial pressure and flow are graphically displayed. Our results are summarized.

THIS GROUP FROM S-20 THROUGH S-27 ON CHART

FINGER RING AVULSION INJURIES

WILLIAM H. FRACKELTON, MD, JACK L. TEASLEY, MD, DONALD M. LEVY, MD and JOHN E. WOODS, MD, Columbia Hospital, Milwaukee

The exhibit consists of models and transilluminated Kodachrome enlargements of: (1) Mechanism of finger ring avulsion injuries, (2) Treatment of finger ring avulsion injuries, and (3) Method of altering a ring for safety. Distribution by a "tear off" sheet pad will provide any viewer of the exhibit with a sheet of directions by which any jeweler can inexpensively alter a ring for safety.

INTRA-ARTERIAL INFUSION WITH 5-FU

SANFORD MACKMAN, MD, LOUIS BERNHARDT, MD, F. J. ANSFIELD, MD, and R. O. JOHNSON, MD, Division of Clinical Oncology, University of Wisconsin, Madison

This exhibit describes the use of intra-arterial infusion for management of head and neck carcinomas, liver metastases, and unresectable pelvic tumors. A movie describing both percutaneous and surgical placement of the catheter is shown and the complications and results summarized.

CANCER OF THE COLON AND RECTUM

AMERICAN CANCER SOCIETY—MILWAUKEE DIVISION, in cooperation with the American Cancer Society—Wisconsin Division

The American Cancer Society's scientific exhibit will illustrate, through the use of color transparencies, precancerous and malignant lesions. The exhibit will also include a display of the equipment necessary for conducting proctosigmoidoscopic examinations and further illustrations of the techniques for examination. The display is part of the Cancer Society's continuing program of professional information for physicians.

RETINAL PATHOLOGY IN RENAL DISEASE

DONALD A. ROTH, MD and BRUNO J. PETERS, MD, Wood VA Hospital and Marquette University School of Medicine

This exhibit consists of enlarged color photomicrographs of kidney biopsy tissue and retinal photographs. The material was selected from the authors' experience with 400 patients who had kidney biopsies and over 1000 retinal photographs. Retinal arteriolar narrowing, hemorrhage, and papilledema may be seen in hypertensive disease from any cause. Retinal edema appears to be a more prominent feature of nephritis. In diabetes, the yellow sharp bordered exudates, microaneurysms, broad irregular veins, and blot or brush hemorrhages aid in distinguishing diabetic retinopathy from changes seen in hypertension and nephritis. The exhibit is modified from one which won an honorable mention award at the AMA meeting in New York in 1965.

THE ENZYMATIC BIOPSY

WILLIAM G. RICHARDS, MD, THEODORE ROWAN, MD, E. BRUCE WOHLWEND, MD and PAUL R. GLUNZ, MD, Clinical Pathology Laboratory, Beaver Dam

The Exhibit will be aimed at the practicing physician with a list of the enzyme tests readily available in the pathologist's laboratory. A brief practical outline of what can be learned from various enzyme studies with a few illustrated cases will be included. The enzymes covered will include: Serum Glutamic Oxalacetic Transaminase, Serum Glutamic Pyruvic Transaminase, Leucine Aminopeptidase, Creatine Phosphokinase, Lactic Dehydrogenase, Serum; Lactic Dehydrogenase, Urine; Lactic Dehydrogenase, Isoenzymes; Acetyl Cholinesterase, Isocritic Dehydrogenase, Serum α Hydroxybutyrate Dehydrogenase, Amylase, Serum; Amylase, Urine; Lipase, Serum; Alkaline Phosphatase, and Acid Phosphatase.

ASPIRIN AND BLEEDING: THE INFLUENCE OF ACETYSALICYLIC ACID ON HEMOSTASIS

EDWIN L. BEMIS, MD, ROBERT S. HAUKOHL, MD and YOSHIRO TAIRA, MD, Department of Pathology and Laboratory Medicine, Deaconess Hospital, Milwaukee

The effect of acetylsalicyclic acid on hemostasis is illustrated by representative cases of menorrhagia, occult blood loss and prolonged bleeding time following the ingestion of aspirin. The Quick Aspirin–Tolerance Test (A.T.T.) for the detection of pseudohemophilia (Minot-von Willebrand syndrome) is described and the value of this test is emphasized in the study of obscure bleeding problems.

WISCONSIN SOCIETY OF PATHOLOGISTS

(1) Demonstration of Gross Tissue Pathology
(2) Forensic Pathology

The exhibit will consist of two booths. One of these booths will be devoted to Anatomical Pathology and will feature presentation of gross tissue pathology. The second booth will be an exhibit on Forensic Pathology. Methods of operation of the Medical Examiner's Office of Milwaukee County will be explored using appropriate illustrative cases.

THIS GROUP FROM S-28 THROUGH S-35 ON CHART

"NOW HEAR THIS"

EMPLOYERS INSURANCE OF WAUSAU in cooperation with the State Medical Society's Division on Otolaryngology of the Commission on State Departments

"Now Hear This" consists of 5 panels, each about 6 feet long. In front of each panel is a "sound deck" with three telephones on it. By picking up the receiver, a visitor hears a running commentary on some phase of hearing, amplifying what he sees before him on the panel. The exhibit deals with five areas of hearing: your ear—how it functions; how to measure noise and control it; how hearing loss is diagnosed and what to do about it; hearing protection; and hearing aids, past and present. Neither the tapes nor materials showing on the panels deals with anything other than the educational aspects of hearing.

TONSILLECTOMY

MAXINE BENNETT, MD and JAMES BRANDENBURG, MD, Division of Otolaryngology, University of Wisconsin Medical Center, Madison

The indications, contraindications, morbidity and mortality, and a movie of the surgical procedure will be illustrated. The operation is a safe and indicated procedure if (1) the general anesthesia is administered by an adequately trained anesthetist, (2) the surgery is performed by an experienced operator, and (3) hemorrhage is controlled. There are many techniques for doing the surgical procedure but the indications and basic surgical principles remain the same. The exhibit will complement and we hope add interest to the section program planned for Thursday morning (May 11): a panel discussion with audience participation on the same subject. A member of the Otolaryngology Division Staff will be present at all times to discuss and answer questions.

THE GLAUCOMA PROBLEM

DIVISION OF OPHTHALMOLOGY, UNIVERSITY OF WISCONSIN MEDICAL CENTER; EDUCATIONAL COMMITTEE, STATE MEDICAL SOCIETY'S SECTION ON OPHTHALMOLOGY; and STATE BOARD OF HEALTH, Madison

The exhibit will consist of four view boxes of stereoscopic external and funduscopic color photographs illustrating various types of glaucoma. Fundamental principles of ophthalmoscopy of normal and glaucomatous optic discs will be stressed. These will be supplemented by a continuous 8-minute movie on the technique of Schiotz tonometry in glaucoma screening as well as demonstration of the technique on a mannequin. Members of the Section on Ophthalmology will be available to teach and also to perform tonometry on all Society members who wish to be tested.

EYE LESIONS OF COMMON INTEREST

WILLIAM E. MEISEKOTHEN, MD and HARRY ROTH, MD, Division of Ophthalmology, University of Wisconsin Medical Center, Madison

The exhibit will consist of five viewers containing stereoscopic external and fundus color photographs selected from material added to our teaching collection in 1966. We anticipate that this exhibit will be of interest to general practitioners and internists as well as ophthalmologists.

AURICULOSTOMY: A NEW METHOD

J. VICTOR BOLGER, MD, in cooperation with the Auros Electronic Corp.

The exhibit will show pictures of patients with this new technique. It will also describe method of performing auriculostomy and instruments and materials used.

MEMORIAL GIFTS . . . .

. . . to the Charitable, Educational and Scientific Foundation of the State Medical Society of Wisconsin serve both the living and pay thoughtful tribute to the memory of a friend, relative, or colleague. A Memorial Card will be sent to the bereaved family. You, as donor, will be mailed a receipt.

THIS GROUP IN AREA S-28 THROUGH S-32 ON CHART

REDUCTION OF BLOOD LOSS FOLLOWING TRANSURETHRAL PROSTATIC RESECTION

PAUL O. MADSEN, MD and RENATE E. MADSEN, MD, VA Hospital, Madison; and Dept. of Surgery, University of Wisconsin Medical School, Madison

This exhibit is concerned with the effect of various agents (aminocaproic acid, conjugated estrogens, carbazochrome salicylate and hypothermia) in controlling blood loss in a series of 240 patients during and following transurethral resection of the prostate. One hundred patients served as controls. Blood loss was measured by colorimetric procedure for hemoglobin and expressed as cubic centimeters per gram of resected tissue. Results demonstrated that blood losses were markedly less for patients receiving aminocaproic acid than for any of the other means employed. The mechanism of action of aminocaproic acid, inhibition of urokinase is discussed.

THE SLEEVE URETHROPLASTY

PAUL O. MADSEN, MD, PALMER KUNDERT, MD and JOHN T. MENDENHALL, MD, VA Hospital, Madison; and Dept. of Surgery, University of Wisconsin Medical School, Madison

A new sleeve approach to urethroplasty applicable in anterior urethral lesions has been described. Detailed technique and results in 21 cases will be presented. The urethroplasty is carried out after complete retraction of the penile skin to the base of the penis, thus omitting a suture line covering the actual operative site. This exhibit will be of interest to general surgeons, plastic surgeons, and urologists. It has been approved by the Medical Illustrations Service at the VA Central Office for showing at meetings of recognized scientific standards.

BONE MINERAL MEASUREMENT IN-VIVO

JOHN R. CAMERON, PhD and JAMES A. SORENSON, University of Wisconsin, Department of Radiology, Madison

Various panels will illustrate the principles involved and the results obtained to date. The use of this new technique in diagnosis of osteoporosis, remineralization studies, etc. will be described. A unit for the actual measurement of bone mineral of volunteers will be present and in operation.

A STUDY OF GLOMERULAR DISEASES

GREGORY J. BEIRNE, MD, ROBERT O. BURNS, MD, WILLIAM L. KOPP, MD and JAMES V. YOUNG, Veterans Administration Hospital, Madison

This exhibit will show morphologic and immunologic studies of various glomerular diseases. The two side panels will each have 3 pairs of enlarged, framed, photomicrographs showing light and electron microscopic findings in the normal glomerulus and in some of the more common glomerular diseases. One pair will show the normal structure of the glomerulus by light and electron microscopy. The remaining 5 pairs will show the typical changes found in adult lipoid nephrosis, membranous glomerulonephritis, acute proliferative glomerulonephritis lupus nephritis, and diabetic glomerulosclerosis. The rear panel will contain a 32 by 24 inch oil painting which depicts a composite glomerulus with surrounding tubules representing the various techniques and staining methods used in the study of renal biopsies. Beneath this painting there will be four lighted view boxes displaying enlarged color transparencies of selected renal biopsy specimens showing some of the more typical patterns of immunofluorescence in glomerular diseases.

MECHANISMS OF HEPATIC COMA

FEVZI PAMUKCU, MD, FREDERICK STEIGMAN, MD and FERNANDO VILLA, MD, in cooperation with the Hektoen Institute for Medical Research of Cook County Hospital, Chicago

Since hepatic encephalopathy is usually associated with a hyperammoniemia, this exhibit presents the mechanisms which produce changes in the ammonium level in the blood and cerebral spinal fluid. The described changes will include both an increase or decrease of the ammonia levels and their influence on the clinical picture of so-called "hepatic coma."

THIS IN CORRIDOR LEADING TO MEETING ROOMS,

URETHRAL VALVES: DIAGNOSIS AND TREATMENT

MARQUETTE UNIVERSITY UROLOGY SECTION in cooperation with the Milwaukee Children's Hospital, Milwaukee

This display will demonstrate the spectrum of urethral valvular lesions. All grades of such lesions, with examples of the secondary changes they produce on the urinary tract will be shown. There will be three lighted panels which will occupy a space 8 feet wide. There will be photographs and x-ray examples of the pathologic lesions, autopsy material, diagnostic techniques and forms of therapy. The spectrum of disease and variations in clinical presentation will be stressed. There will also be a continuous running movie of cinecystourethrograms with a sound tract, to demonstrate the spectrum of disease. The Mark-IV type projector will be used for demonstrating the movie.

Technical Exhibits

22—ABACUS, INC., Janesville
81—ABBOTT LABORATORIES, North Chicago, Ill.
100—AMERICANA CORPORATION, New York City
46—ARNAR–STONE LABORATORIES, INC., Mount Prospect, Ill.
39—ASTRA PHARMACEUTICAL PRODUCTS, INC., Worcester, Mass.
102—AUTOMATED BILLING CONTROL, INC., Milwaukee
62—AYERST LABORATORIES, Chicago, Ill.

64—BARR X-RAY COMPANY, Milwaukee
36—W. A. BAUM COMPANY, INC., Copiague, N. Y.
9—BEECHAM RESEARCH LABORATORIES, New York City
61—BENCO OPHTHALMIC LABORATORIES, Milwaukee
97—THE BORDEN COMPANY, New York City
83—BREON LABORATORIES, INC., New York City
96—BURROUGHS WELLCOME COMPANY, Tuckahoe, N. Y.

34—CARNATION COMPANY, Los Angeles, Calif.
71—CIBA PHARMACEUTICAL COMPANY, Summit, N. J.

50—THE COCA COLA COMPANY, Atlanta, Ga.
40—CREATIVE SYSTEMS INC., Waterloo, Ia.

59—DOME CHEMICALS, INC., New York City
48—DOYLE PHARMACEUTICAL COMPANY, Minneapolis, Minn.

45—EATON LABORATORIES, Norwich, N. Y.
23—ECONO LEASE OF MILWAUKEE, Milwaukee
58—ENCYCLOPAEDIA BRITANNICA, Chicago, Ill.
54—MARSHALL ERDMAN & ASSOCIATES, Madison

79—A. J. FARNHAM COMPANY, INC., Milwaukee
19—H. G. FISCHER & COMPANY, Franklin Park, Ill.
80—FLINT LABORATORIES, Morton Grove, Ill.

68—GEIGY PHARMACEUTICALS, Yonkers, N. Y.
24—GENERAL ELECTRIC X-RAY DEPARTMENT, Milwaukee
59—GENTEC HOSPITAL SUPPLY CO., Milwaukee

92, 93—HOECHST PHARMACEUTICALS, INC., Cincinnati, O.
99—HEWLETT PACKARD, Skokie, Ill.
42—HURLEY X-RAY COMPANY, Milwaukee

95—FRANK J. ITALIANO, INC., La Crosse

14—KNOLL PHARMACEUTICAL COMPANY, Orange, N. J.
4—KREMERS–URBAN COMPANY, Milwaukee

25—LAAB'S INC., Milwaukee
13—LA CROSSE MEDICAL SUPPLY COMPANY, La Crosse
5—LAKESIDE LABORATORIES, INC., Milwaukee
35—LANGER LABORATORIES, INC., Milwaukee
3—LEDERLE LABORATORIES, Pearl River, N. Y.
43, 44—ELI LILLY & COMPANY, Indianapolis, Ind.
10—J. B. LIPPINCOTT COMPANY, Philadelphia, Pa.
49—LITTLE PRESS, INC., Minneapolis, Minn.
1—LOEWI & COMPANY, Milwaukee
87—LOMA LINDA FOODS, Riverside, Calif.

8—MADLAND LABORATORIES, INC., Milwaukee
88—MARION LABORATORIES, Kansas City, Mo.
66—McNEIL LABORATORIES, Fort Washington, Pa.
56—MEAD JOHNSON LABORATORIES, Evansville, Ind.
20—MEDCO PRODUCTS, INC., Tulsa, Okla.
72—MEDICAL PROTECTIVE COMPANY, Fort Wayne, Ind.
38—MEDICO-MART, INC., Milwaukee
69, 70—MERCK SHARP & DOHME, West Point, Pa.
47—MIDWEST PROFESSIONAL CONTRACTORS, Madison
60—MILLER PHARMACAL COMPANY, INC., West Chicago, Ill.

104—3M BUSINESS PRODUCTS SALES, Milwaukee
101—MONARCH LIFE INSURANCE COMPANY, Madison and Milwaukee
52—C. V. MOSBY COMPANY, St. Louis, Mo.
21—MUTUAL BENEFIT LIFE INSURANCE COMPANY, Madison

51—ORTHO PHARMACEUTICAL CORPORATION, Raritan, N. J.

27—PARKE, DAVIS & COMPANY, Detroit, Mich.
91—PFIZER LABORATORIES, New York City
85—PHYSICIANS & HOSPITALS SUPPLY, Minneapolis, Minn.
77—PICKER–NUCLEAR, Chicago, Ill.
95—PLEASONING, La Crosse
15—PROFESSIONAL ASSOCIATION FOR CIVIC EDUCATION, Waterloo
6—PROFESSIONAL BUSINESS SERVICE, La Crosse

2—J. B. ROERIG & COMPANY, New York City
41—ROCHE LABORATORIES, Nutley, N. J.
53—ROSS LABORATORIES, Columbus, O.
84—ROWELL LABORATORIES, Baudette, Minn.

67—SANDOZ PHARMACEUTICALS, Hanover, N. J.
63—W. B. SAUNDERS COMPANY, Philadelphia, Pa.
11—SCHERING CORPORATION, Union, N. J.
12—G. D. SEARLE & COMPANY, Chicago, Ill.
55—SEEFURTH & McGIVERAN, Milwaukee
103—SENTRY MEDICAL SYSTEMS, INC., Chicago, Ill.
65—SICKROOM SERVICE, Milwaukee
98—SIEMENS MEDICAL OF AMERICA, Addison, Ill.
78—SMITH KLINE & FRENCH LABORATORIES, Philadelphia, Pa.
74—SMITH, MILLER & PATCH, New York City
82—E. R. SQUIBB & SONS, New York City
94—STUART COMPANY, Pasadena, Calif.

73—THOMSON & McKINNON, Milwaukee

86—ULMER PHARMACEUTICAL, Minneapolis, Minn.
89—UPJOHN COMPANY, Kalamazoo, Mich.
7—U. S. VITAMIN & PHARMACEUTICAL CORPORATION, New York City

75—WARNER–CHILCOTT LABORATORIES, Morris Plains, New Jersey
37—WARREN–TEED PHARMACEUTICAL INC., Columbus, O.
90—WESTWOOD PHARMACEUTICAL, Buffalo, N. Y.
76—WINTHROP LABORATORIES, New York City
57—WISCONSIN 7-UP BOTTLERS, Madison
17, 18—WISCONSIN PHYSICIANS SERVICE, Madison

33—ZIMMER MANUFACTURING INC., Warsaw, Ind.

SMS Members Invited to Wisconsin Dental Meeting

All members of the State Medical Society of Wisconsin are invited to attend the 97th Annual Session of the Wisconsin State Dental Society at the Milwaukee Auditorium, April 24–26. A number of fine scientific programs of mutual interest to both professions will be presented all three days. Your current membership card is all that is required to register. Registration will be conducted in the inner corridor of the Auditorium, to the left of the Kilbourn Avenue entrance.

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Primary Torsion of the Greater Omentum

By MARVIN E. SATTLER, M.D. and MOHAMED I. HUSSAIN, M.D.
Milwaukee, Wisconsin

■ TORSION OF THE greater omentum is a relatively rare clinical phenomenon. It may occur as a primary entity, unassociated with intra-abdominal disease, as it may be secondary to inflammatory lesions, adhesive bands, hernias, tumors, cysts, or malformations of the omentum. It is almost always a surgical rather than a preoperative diagnosis.

Pierre de Marchette first described torsion of the omentum in 1851.[1] Eitel[2] recorded a case of primary torsion in 1899. Mainzer and Simos,[3] in 1964, gathered 165 cases of primary torsion of the omentum from the literature.

Several theories have been advanced to explain the pathogenesis of omental torsion. Some of these are: (1) sudden strain, cough, or change in position, (2) trauma to the abdomen, (3) hyperactive peristalsis of the intestine, (4) excessive length and mobility of the larger and longer right side of the greater omentum, (5) obesity and advanced age, (6) malformations of the omentum, (7) overeating, and (8) presence of inflammatory focus which has been suspected of initiating torsion of the omentum.

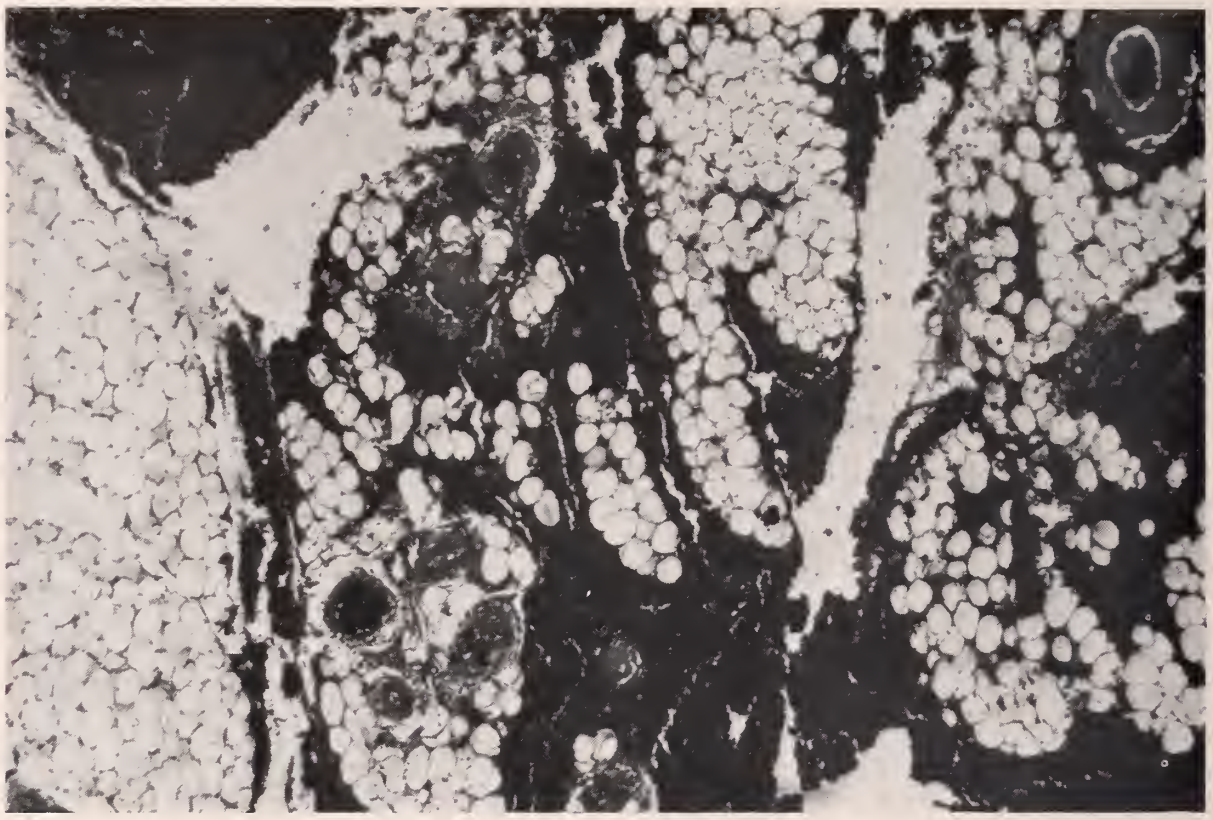
It is well known that the omentum has a protective function within the peritoneal cavity and has been called the "policeman of the abdomen." In the presence of inflammatory conditions, the omentum will attempt to seal off inflammatory conditions of the bowel. It will also block off hernial orifices; and its effective mobility is shown by the fact that whether the lesion is in the diaphragmatic roof of the abdomen, or on the floor of the pelvis, the omentum can and does find its way to wall off the pathology.

Payr[4] suggested that venous engorgement resulted in straightening of the arteries of the omentum which in turn acted as an axis for rotation of the omentum. He was able to reproduce this torsion experimentally by changing the specific gravity of the omentum by implanting foreign objects in its distal edge. Pagge[5] felt that torsion was a recurrent, reversible phenomenon and responsible for many unexplained abdominal discomforts that do not become surgical. Thus many cases of idiopathic abdominal pain such as "abdominal angina" might be caused by recurrent torsion, or volvulus, of the omentum.

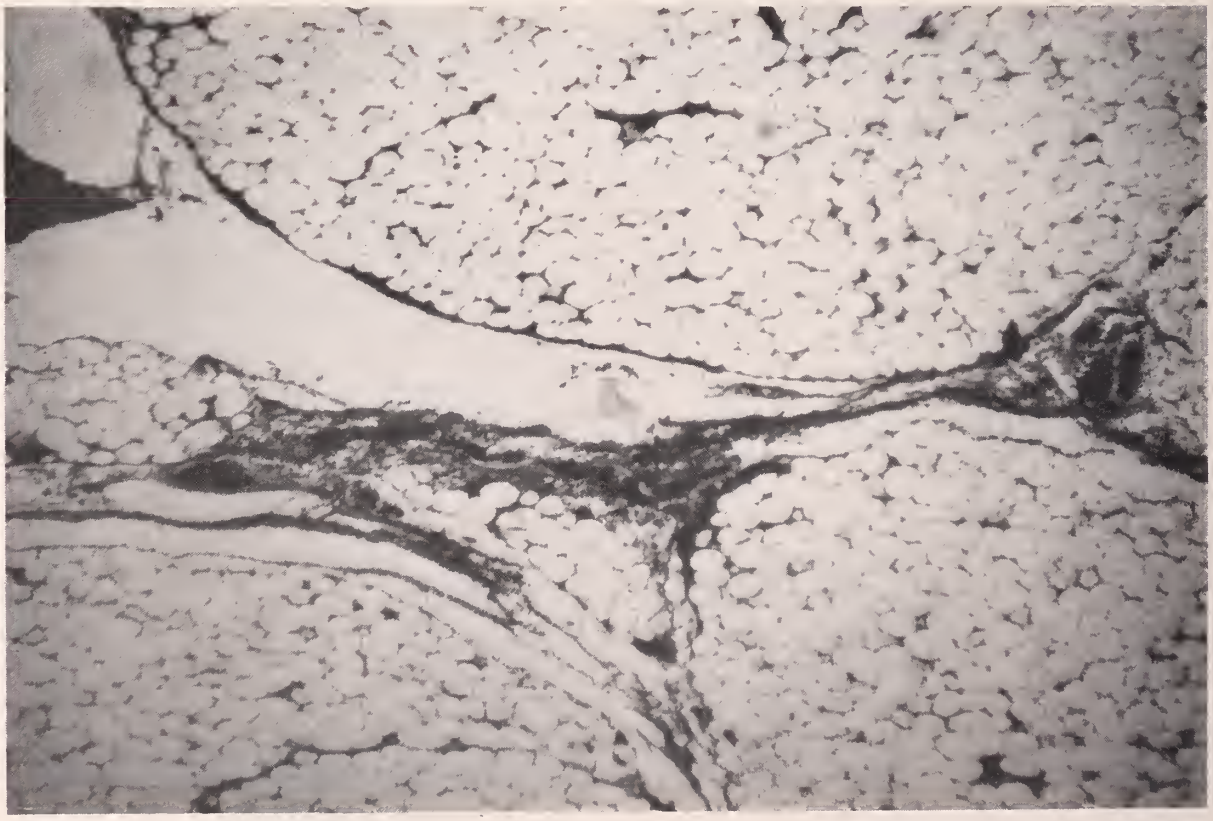
Clinically, this condition is very difficult to diagnose preoperatively. It may mimic acute appendicitis. But when a normal appendix is found, despite typical signs and symptoms, torsion of the greater omentum should be suspected. Serosanguinous fluid is usually present, as well as a mass. This mass may be delineated preoperatively if the condition is kept in mind.

Most of the patients in the cases reviewed had symptoms of 48 hours duration with persistent right lower quadrant pain. Nausea and vomiting were inconstant findings. Acute appendicitis was diagnosed preopera-

From Mount Sinai Hospital.



Figures 1 and 2—Microphotographs of two cases of torsion of the omentum with gangrene, showing necrosis and multiple thrombosis in the vessels.



tively in 119 of 165 cases collected in the literature by Mainzer and Simos.[3] In 18 other cases, acute cholecystitis was the preoperative diagnosis. The gross pathologic findings ranged from edematous congestion of the omentum to frank gangrene. Autoamputation of the omentum has also been reported. The microscopic findings included congestion, inflammation with hemorrhage and edema, and thrombosis of blood vessels with necrosis of all dependent cellular elements (Figs 1 and 2).

Thus, torsion of the omentum, either primary or secondary, may be a decisive factor in the pathogenesis of the acute surgical abdomen.

Treatment is resection of the involved necrotic omentum. This procedure should not be taken lightly, since injury to the transverse colon can occur by careless clamping of the omentum. The omentum should not be detorsed prior to clamping because of the possibility of releasing an embolus. It is also very important to carefully tie the blood vessels on the side of the normal omentum since an improperly tied artery may retract into the normal tissue and produce serious, even fatal, bleeding postoperatively.

CASE REPORTS

Case 1: A 46-year-old white man, well developed and in previously good health, was admitted to the hospital on the afternoon of Feb. 24, 1966, complaining of pain in the abdomen of two days duration. The pain was localized in the right lower quadrant and had become increasingly severe. It was associated with nausea and anorexia, but no vomiting or diarrhea. Approximately two hours prior to admission, the pain was reported to have increased in intensity. There was no history of trauma, no history of unusual activity, and no history or an unusually large intake of food. There was no upper respiratory infection. This patient had been seen by his family physician who noted that his urine showed many erythrocytes. He was admitted to this hospital with a differential diagnosis of acute appendicitis or a right ureteral stone. The patient's history was not significant nor was his family or social history.

Physical examination revealed a well developed, well nourished white man in acute pain. Pulse rate was 100 and regular; blood pressure, 140/70 mm Hg; and temperature, 99.8 F. The abdomen was scaphoid in shape. There was marked localized tenderness in the right lower quadrant over McBurney's point, with rebound tenderness present. No masses were palpable. Rectal examination showed no abnormality. White blood cell count was 13,000 per cu mm. Urinalysis revealed a specific gravity of 1050, acid. There were traces of albumin and blood

Figures 3 and 4—Photographs taken at surgery showing counter-clockwise rotation of free edge of the omentum resulting in torsion and gangrene.

with 15 erythrocytes per high-power field. An emergency intravenous pyelogram was reported as normal.

A clinical diagnosis of acute appendicitis was made and the patient was taken to surgery. At surgery, a McBurney incision was made. Approximately 200 ml of serosanguinous fluid was found in the peritoneal cavity. The appendix appeared to be normal. Exploration of the abdomen at this point revealed a dusky indurated gangrenous midline mass which could not be mobilized into the incision. The McBurney incision was therefore closed and a right paramedian incision was made. The mass proved to be the greater omentum, twisted on itself two and a half to three times, and the distal portion was grossly gangrenous (Figs 3

and 4). The abdomen was then explored completely and found to be entirely normal. The omentum was resected, the abdomen closed, and the patient made an uneventful recovery. He was discharged on the seventh postoperative day.

Pathologic diagnosis was volvulus of the omentum with infarction.

Case 2: On May 9, 1962, a 26-year-old white man was admitted to this hospital with a chief complaint of continuous abdominal pain of four days duration. There was no history of nausea, vomiting, or diarrhea; no history of genitourinary symptoms, or upper respiratory infection. History revealed that the patient had had an appendectomy six years prior to admission.

Physical examination revealed a well developed, well nourished white man in moderate distress from right lower quadrant pain. Pulse rate was 84 and regular; blood pressure, 120/80 mm Hg; temperature, 99.0 F. The abdomen was flat and soft. There was slight localized tenderness with guarding in the right lower quadrant, and some rebound tenderness. The rectal examination was normal. The white blood cell count was 9,000 per cu mm. Serum amylase was 64 mg per 100 ml. Urinalysis was entirely normal. The barium enema was normal.

The patient was taken to surgery with a presumptive diagnosis of appendicitis in an appendiceal stump, but at the time of surgery the omentum was found to be twisted on itself approximately two times. The distal portion of the omentum was grossly gangrenous. The omentum was resected and the patient made an uneventful postoperative recovery. He was discharged on the fifth postoperative day.

Pathologic diagnosis was infarction of the omentum.

COMMENT

We have presented two cases of idiopathic primary volvulus of the greater omentum with gangrene to be added to the literature. The etiology, pathology, symptomatology, and surgical treatment have been reviewed.

Volvulus of the greater omentum should be added to the differential diagnosis of acute abdominal pain. When serosanguinous fluid is found in the presence of a normal appendix, the surgeon must examine the omentum particularly when exploring the abdominal cavity.

One of our patients was explored through a right McBurney incision which was totally unsatisfactory and inadequate for complete exploration. We suggest that perhaps a McBurney incision should not be used since it is inadequate for any surgical procedure other than a simple appendectomy.

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LATE RECOGNITION AND TREATMENT OF TRAUMATIC DIAPHRAGMATIC HERNIAS

W. D. Schwindt and J. W. Gale, Department of Surgery, University of Wisconsin, Madison, *Arch. Surg.* 94:330–334 (Mar) 1967.

The unrecognized traumatic diaphragmatic hernia may result in bowel obstruction or perforation. Of the 12 patients reviewed one month or more post injury, five were asymptomatic but had an abnormal chest roentgenogram, which led to the diagnosis. Three patients had pulmonary complaints of dyspnea or chest pain while the remaining patients had primarily gastrointestinal symptoms. The diagnosis was made in most patients from the chest film; however, barium gastrointestinal studies as well as pneumoperitoneum were diagnostic aids. The stomach and colon were the most commonly displaced organs; however, the spleen was occasionally incarcerated in the thorax. The need for a thoracic surgical approach is stressed as 2 of the 11 patients operated upon initially underwent an unsuccessful attempt at repair through an abdominal approach. The occurrence of rib and pelvic fractures in association with diaphragmatic rupture is noted.

BOOK PUBLISHED: HISTORY OF U. OF W. MEDICAL SCHOOL

"The University of Wisconsin Medical School: A Chronicle, 1848–1948," is a new book written by Paul F. Clark, Ph.D., that will be officially published on Alumni Day, May 26, by the UW Press for the Wisconsin Medical Alumni Association. Prepublication orders are being accepted at $8.50 per copy. Post publication price will be $10.00. A booth will be set up at the Annual Meeting of the State Medical Society May 9–11, in Milwaukee, for anyone interested in purchasing it.

Unusual Ocular Complications in a Patient with Macroglobulinemia

By BILL L. MADDIX, M.D., Monroe, Wisconsin

■ SINCE 1944, when Waldenström[1] described the clinical entity of macroglobulinemia bearing his name, it has become evident that this dysproteinemia can take two definite forms. First, a malignant form which is slowly progressive. The average duration is 36 to 48 months after detection. Death usually occurs secondary to hemorrhagic diathesis, overwhelming infections, neurologic manifestations, or severe anemia. Second, the benign form was originally thought to have an average duration of approximately 70 months after detection. However, Bayrd[2] and his associates pointed out two patients who have lived 10 to 18 years. It is becoming more apparent that the benign form of primary macroglobulinemia is a more prominent clinical entity than previously realized and may be present for many years prior to death.

CLINICAL FEATURES

Waldenström's primary macroglobulinemia is a monoclonal dysproteinemia found predominantly in males (2 to 3:1 ratio) in an age group usually from 50 to 70 years. Careful examination is mandatory to eliminate the possibility of macroglobulin secondary to malignant neoplasms, myeloid leukemia, severe lupus erythematosus, rheumatoid arthritis, other collagen diseases, nephrosis, cirrhosis, purpura macroglobulinemia of Waldenström, primary amyloidosis, primary cryoglobulinemia, and chronic infections such as tuberculosis, lues, toxoplasmosis, kala-azar, chronic hepatitis, and trypanosomiasis. Bayrd[2] and his associates have estimated that 15% to 20% are asymptomatic when first seen. Symptoms are usually nonspecific consisting of anorexia, general lassitude, malaise, dyspnea, weight loss, frequent infections, and bleeding tendencies, especially bleeding of the gums, epistaxis, and occasionally gastrointestinal bleeding or hemoptysis. Infrequently, the patient presents with Raynaud's phenomenon or the Bing–Neel syndrome with paresis of a lower extremity, optic neuritis, irritability, personality changes, delusions, mental deterioration, myelitis, polyradiculitis, and pyramidal tract signs.[3] Rarely coma paraproteinemicum has been reported.

Physical findings may reveal signs reflecting anemia, microlymphadenopathy, splenomegaly, hepatomegaly, or a combination, and ocular disturbances.

OCULAR MANIFESTATIONS

Ophthalmoscopic abnormalities are frequently encountered phenomena and visual disturbances have been estimated to be present in 33% to 70% of the reported cases of primary macroglobulinemia. One of Waldenström's[1] original cases was presented with the initial complaint of loss of vision due to central vein thrombosis.

Funduscopic findings are frequently not extensively studied and few of the eyes from macroglobulinemic patients have been examined post mortem. The most consistent observations have been beading of the vessels, engorgement of the vessels, hemorrhages, and central vein thrombosis. Bilateral central vein thrombosis in a Negro patient who had macroglobulins and leukemia was reported by Coyle[4] and his group. Spalter[5] described the funduscopic spectrum as (1) dilatation and tortuosity of the veins, (2) peripheral venous thrombosis and hemorrhage, and (3) central or branch vein occlusion. He feels that this series of events can be explained on the basis of hyperviscosity of the serum in these patients, while Pachter[6] and his associates feel that the abnormalities of the platelets play a prominent role as well. Berneaud–Kötz and Nover[7] described the findings as "fundus paraproteinemicus" with sludging, stasis, hemorrhages, exudates and varicosities as

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outstanding features. Harders[8] described similar findings of congestion, engorgement of vessels and hemorrhages in the conjunctiva. Ackerman[9] reported the post mortem findings of an eye which revealed PAS positive material in the blood vessels, which he felt was due to the macroglobulins. Similar material has been reported by Cagianut[10] and his associates in eight cases with examination of post mortem eyes. A description of homogenous deposits in the retina and intermittent deposits in the engorged vessels was reported. Chemical analysis of the substances was compatable with abnormal macroglobulins which were believed to cause irreversible damage to the retina. It was believed that these findings were characteristic of primary macroglobulinemia and that they are not found in multiple myeloma or secondary macroglobulinemia. Recently Schmidt[11] and associates reported a case which had retinopathy of paraproteinemia and the findings contained homogenous material of the large vessels and heart as has been reported in some of the eye vessels mentioned previously.

LABORATORY FEATURES

Laboratory data can be very helpful in suspecting macroglobulins and are necessary for a definite diagnosis of primary macroglobulinemia. The peripheral blood smear may reveal rouleaux formation and suggest a normocytic, normochromic anemia. The cholesterol level may be low, uric acid levels may be elevated, and approximately 10% of the patients will show Bence–Jones protein in the urine. Bone marrow examination ranges from normal to erythroid hyperplasia to infiltration of lymphocytoid cells which frequently reveal PAS positive staining material. Inconsistent coagulation factor deficiencies may be encountered.[4]

The Sia water test is the simplest screening test available for primary or secondary macroglobulins and is usually positive. Paper electrophoresis of serum proteins will reveal a monoclonal spike of gamma-globulin fraction. Further screening techniques of the electrophoretic pattern such as PAS staining for carbohydrate content, which is usually higher in primary macroglobulinemia,[12,13] DL-penicillamine treated paper electrophoresis as described by Leder[14] and starch-gel electrophoresis with the use of 2-mercaptoethanol to demonstrate macroglobulins[15] may be used.

Thermoviscosimetry,[13] (the determination of serum viscosity at different temperature ranges), has consistently revealed markedly increased levels with macroglobulins. Waldenström has proposed an index of serum viscosity in which a value greater than 120 indicates the diagnosis.

The final diagnosis must be made by ultracentrifugation with the demonstration of greater than 5% high molecular weight macroglobulins in the S 14 to S 28 range. Secondary macroglobulinemias usually are found in the S 7 to S 14 range. There is considerable evidence that immunoelectrophoresis can further distinguish between primary and secondary macroglobulinemias. Osserman and Lawlor[16] described a pattern in Waldenström's macroglobulinemia related to the $Beta_2$-M fraction which they felt was diagnostic, and a second pattern frequently seen, which was highly suggestive of the entity.

TREATMENT

Many treatment schedules have been tried, but none is entirely successful. The use of steroids has generally been disappointing, but has been helpful when hemolytic anemia is a serious problem. The chemotherapeutic drugs have been tried with varying degrees of success. Bayrd and associates[2] reported improvement with chlorambucil with nine patients, but most reports have not produced significant remission.[9] Other antimetabolites have also been disappointing.[17]

Penicillamine has been used with some success also, but all patients do not seem to respond to this drug which breaks down the sulfur bonds causing depolymerization of the macroglobulins. Ackerman[9] reported the reversal of funduscopic findings in his patient on penicillamine therapy. The toxic effects have been troublesome, with anorexia, nausea, erythematous rash, and drowsiness frequently being reported.

Lastly, plasmapheresis, a method of removing the plasma and reinfusion of the red cells, has been reported as temporarily successful. Coyle[4] and associates reported reversal of retinal findings by this method. Reversal of other symptoms is common also, but remissions are of short duration since the underlying disease process is unaltered.

CASE REPORT

This 67-year-old white man was first seen in the ophthalmology department on Oct. 15, 1965, complaining of poor vision in the right eye. He stated that he noted complete loss of vision shortly after removal of a right lower bicuspid in August 1965. This gradually improved, then became worse again after treatment with eye drops prescribed by his local ophthalmologist who felt that funduscopic examination was typical of retinal vein thrombosis. The patient was initially given nitroglycerine, pilocarpine 4%, and acetazolamide (Diamox). Twenty-four hours prior to examination at the clinic, he had received no glaucoma medication.

Examination of the right eye revealed inability to count fingers at a distance of 24 inches. The pupil was semi-dilated and fixed, the cornea appeared steamy, and the eye grounds were difficult to visualize. Some clearing was obtained with instillation of glycerine. The nerve head was orange colored and the optic cup appeared shallow. The tension of the right eye by Schiotz tonometer was 26.6 as compared with 12.2 in the left eye. Gonioscopy in the office was difficult because of clouding of cornea. The left angle was Grade IV and the cornea appeared normal. Perimetric examination revealed a large central scotomata in the right eye, but the left eye was normal. Medical treatment failed to improve vision in the right eye and it became painful.

The patient was admitted to the hospital. There was extensive vascularization of the iris and blood vessel infiltration of the angle for 360 degrees. In the opinion of the ophthalmologist, it is unusual for rubeosis to appear within only two months after a central vein thrombosis.

There were several pertinent facts in the medical history. The patient considered himself in general good health in spite of a known anemia of many years duration. Approximately two months prior to admission, the patient had had intermittent rectal bleeding. His history revealed a gastroenterostomy in 1917, secondary to food poisoning in the army. He had had pneumonia in April 1965, which responded readily to treatment. Stools for occult blood were positive at that time, but the patient refused to have further studies. His hemoglobin level at this time was 8.6 gm per 100 ml. He was treated with oral iron for several months with only a rise of 1.0 gm.

Physical examination revealed a pale, well developed, well nourished, white man who appeared in acute distress from the pain in his right eye. No lymphadenopathy was noted. The chest was clear to auscultation and percussion. Blood pressure was 110/68 mm Hg, pulse rate 94 per minute, and a Grade II systolic murmur was heard over the precordium which projected slightly to the carotids. Neither the liver nor spleen were palpable. The extremities, central nervous system, rectal examination, and spine and joints were not remarkable.

Sigmoidoscopy to 25 cm was normal except for a few small internal hemorrhoids. Chest x-ray film revealed arteriosclerotic changes of the aorta and some hilar calcified lymph nodes. Barium enema was not remarkable. The upper gastrointestinal x-ray series showed a normally functioning gastroenterostomy. The electrocardiogram revealed complete right bundle branch block and nonspecific T-wave changes of inversion.

On Oct. 19, 1965, a Shay filtering operation was performed on the right eye without incident. No bleeding was encountered and a moderately large peripheral iridectomy was done. The anterior chamber was restored with normal saline and air, and no evidence of a leak was noted in the filtering bleb. On the second postoperative day, the eye began to show appreciable amount of blood in the anterior chamber and the intraocular pressure rose to 56. A paracentesis of the cornea was performed under local anesthesia and a large amount of clotted blood escaped requiring irrigation of the anterior chamber with thrombolysin solution. The anterior chamber was finally freed of all clotted blood and was filled with air and normal saline containing penicillin. Atropine drops 1% were instilled and Ophthocort ointment was applied. The procedure controlled the tension and the patient continued an uneventful recovery.

Laboratory results revealed the following values: hemoglobin, 8.2 gm per 100 ml; hematocrit reading, 26%; white blood cell count, 4,700 per cu mm, with a differential count of 67 segmented neutrophils, 32 lymphocytes, and 1 monocyte. Urinalysis revealed a specific gravity of 1.020, 5.5 Ph., 1 plus protein, 1 to 2 white blood cells and 0 to 1 red blood cells. Stools for occult blood were normal on four occasions. Dianex blue test was normal for hydrochloric acid (HCl). Lactic dehydrogenase (LDH) was 250 units. Cholesterol content was 154 mg per 100 ml. Cell indices revealed mean corpuscular volume (MCV) of 81 u^3, MCHG 27 umg, and MCHC 34%. Prothrombin time (PTT) was 82 seconds. Serum iron was 37 (normal: 65 to 175), iron-binding capacity 251 (normal: 250 to 410), and 15% saturation (normal: 20 to 55%).

Cryoglobulins and Bence–Jones proteins were negative. Serum proteins were 7.95 gm per 100 ml with 2.75 albumin and 5.20 globulin. A two-hour postprandial blood sugar determination was 106 mg per 100 ml. Total bilirubin was 0.4 mg per 100 ml with free bilirubin 0.3 and combined bilirubin 0.1. Direct and indirect Coombs tests were negative. Sia water test was positive. The sedimentation rate was 138 mm per hour. The platelet count was 290,000 per cu mm, reticulocyte count 1.7%, and stool fat was normal. Bone marrow determination revealed a moderate hyperplasia of the red blood cell series, particularly of the normoblasts and erythroblasts, with a granular erythroid cell ratio of 3:1.2. The nonnucleated red blood cells appeared to be spherocytic in many instances. A few foamy

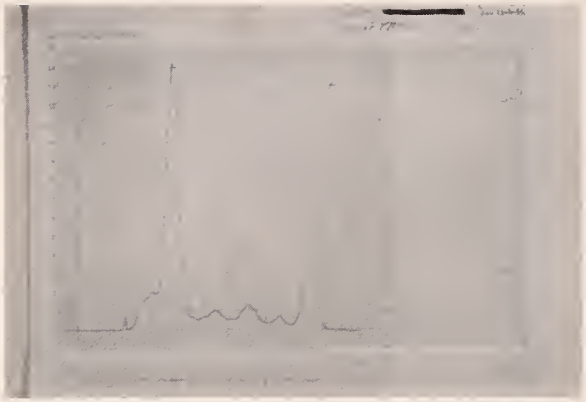

Fig. 1—Protein paper electrophoresis. Large monaclonal gamma glabulin spike compatable with macroglabulinemia.

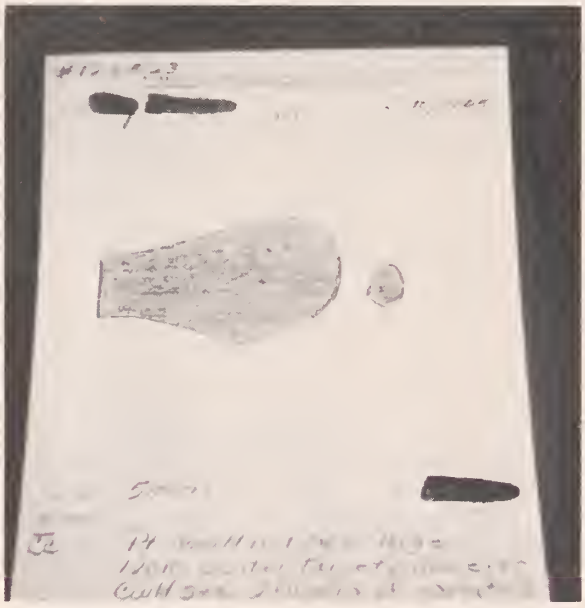

Fig. 2—Tangent fields. Large scotomata of right eye

plasma cells which were felt to be lymphocytoid in type were noted.

Protein paper electrophoresis showed a sharp gamma peak, as shown in Figure 1. Ultracentrifugation revealed 23.6% of Class S 19 macroglobulins, as shown in Table 1. This verified the diagnosis of macroglobulinemia, but it was felt that the iron-deficiency anemia was not typical, and iron-dextran complex (Imferon) therapy was instituted. The patient responded as shown in Table 2. Since his hospitalization he has been asymptomatic except for considerable loss of vision in his right eye.

Recent follow-up on Apr. 27, 1966, revealed the patient to be asymptomatic and he has continued all of his previous activities. Examination of the right eye revealed a dense cataract, vascularization of the iris and internal sclera, and perception of light and detection of gross objects only. Pressure was normal. Follow-up photographs of the vascularization of the iris and eye are shown.

TABLE 1—*Serum Macroglobulins*

Class	Gm per 100 ml
S 19	2.32
S 7	1.80
S 4 (Albumin)	4.93
S 29	0.23
S 23	0.55

TABLE 2

Dates	Hemoglobin (Gm)	Hematocrit Reading (Per Cent)
10/11/65	8.2	26
10/14/65	8.7	26
10/18/65	8.7	27
10/20/65	8.4	26
11/30/65	8.5	28
1/ 5/66	9.1	28
2/11/66	11.0	33
4/27/66	11.7	35

His hemoglobin level was 11.7 gm per 100 ml, white blood cell count 6,500 per cu mm with a differential count of 48 segmented neutrophils and 41 lymphocytes. The sedimentation rate remained elevated at 118 mm per hour. The urinalysis revealed no protein, and total serum proteins were 8.5 gm per 100 ml with 3.2 of albumin and 5.3 of globulins.

COMMENT

The patient's history of anemia of one year's duration unresponsive to various forms of oral therapy is an interesting phenomenon. His asymptomatic course prior to admission, except for his episode of pneumonia and for showing occult blood, suggests that he had adapted well to a compromised hemoglobulin. No signs or sources of bleeding could be detected. Bone marrow examination and serum-iron studies supported the diagnosis of iron-deficiency anemia. No evidence of hemolysis could be detected. The negative Dianex blue test is suggestive of lack of or reduced HCl in the stomach. Absorption of iron is accomplished chiefly in the duodenum and jejunum, slightly in the stomach and ileum and possibly small amounts in the colon. Absorption is best in the ferrous form and HCl plays a role in the absorption which is not fully understood, but probably prevents the formation of insoluble iron compounds and assists in breaking down iron to smaller particles.

To my knowledge, reduced HCl of the stomach and malabsorption of iron has not been previously reported in Waldenström's macroglobulinemia. The response of our pa-

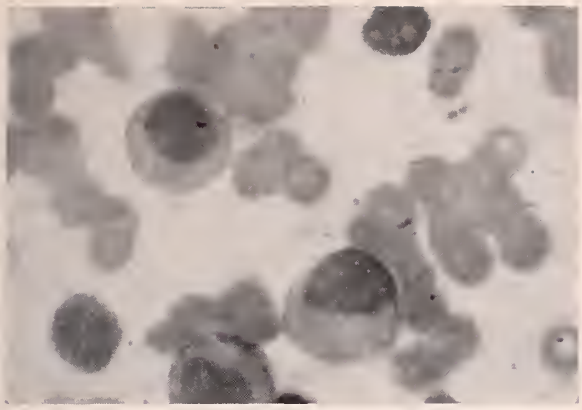

Fig. 3—Lymphoplasmacytoid cells suggestive of macroglabulinemia.

Fig. 4—Fundus of left eye showing tartuous vessels of the retina.

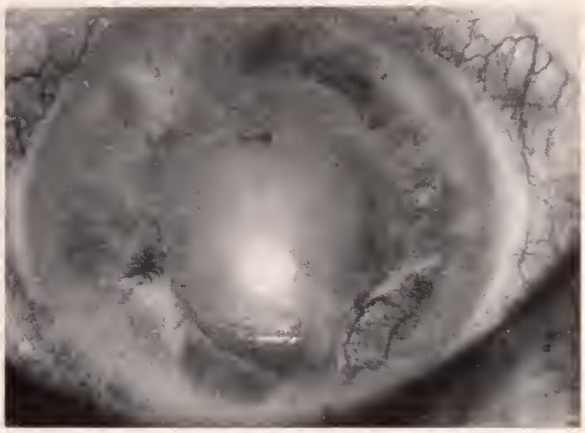

Fig. 5—Dense cataract, right eye. Vascularization of the iris representing rubeosis in a mocroglobulinemic patient.

tient to Imferon therapy supports a malabsorption phenomenon after failure to respond to oral iron products.

Central vein thrombosis has been reported on several occasions with primary macroglobulinemia and must be considered in the differential diagnosis when found. The unusual features of rubeosis and subsequent glaucoma have not been reported before. The development of rubeosis following a tooth extraction and local anesthesia has been previously reported, but the rapid vascularization over a two-month period is unusual. Therefore, it is reasonable to assume that the primary macroglobulinemia contributed to the rapid development of the rubeosis or is responsible for it.

SUMMARY

A case of Waldenström's macroglobulinemia stressing the ocular and hematologic manifestations is reported. The usual funduscopic findings of dilated tortuous venous engorgement, hemorrhages, exudates, and venous thrombosis are discussed. The unusual ocular finding of rubeosis with subsequent glaucoma is described. The iron-deficiency anemia unresponsive to oral therapy, but responding to Imferon therapy, is suggestive of a malabsorption syndrome of iron. The low or absent HCl levels in the stomach may be responsible for this phenomenon. The two unusual aspects of the case have not previously been reported in the literature to my knowledge.

A brief review of the various treatments of penicillamine, plasmapheresis, and antimetabolites are discussed.

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WATER TEST IN EVALUATION OF GASTROESOPHAGEAL REFLUX IN CORRELATION WITH PYROSIS

ANDREW B. CRUMMY, MD, Department of Radiology, University of Wisconsin Medical Center, Madison: *Radiology* 78:501–504, 1966.

Pyrosis is a frequently encountered symptom generally attributed, largely on circumstantial evidence, to the esophagitis which results from gastroesophageal reflux. Since reflux is an intermittent phenomenon, it is desirable to have a simple physiologic method of inducing it rather than relying on chance observations. Such a method is the water-siphonage test described by De Carvalho.

The water test is performed as follows: During the routine examination when the patient is supine, he is turned into right posterior oblique position in relation to the fluoroscopic table so that the region of the cardioesophageal junction will fill with barium. He is then asked to take a swallow of water through a straw (15–30 cc) while the gastroesophageal junction is observed fluoroscopically. Normally there is no reflux of barium into the esophagus. The test is positive when there is abrupt eruption of the barium mixture into the esophagus, usually to the level of the pulmonary hilus and frequently above the aortic arch. An analysis of the findings and the correlation with the clinical symptoms in 650 consecutive cases performed by the author forms the basis of the report.

A positive water test was seen in 67 (10.3%) of the patients examined. Forty-six (68.6%) of these had pyrosis as a complaint. Conversely 583 (89.7%) did not have reflux when tested with water and only 20 (3.4%) of these complained of pyrosis. Sixty-six (10.1%) of the total group complained of pyrosis and 46 (69.6%) of these had a positive water test. On the other hand, 20 (30.4%) with pyrosis showed no reflux when tested. It is concluded therefore that pyrosis is approximately 20 times as common in patients with a positive water test, and those with a positive water test complain of pyrosis 2.3 times oftener than those who do not. Hiatus hernias were found in 46% of the patients. Twenty-two had pyrosis and in 20 (91%) the water test was positive. Of 24 asymptomatic patients with a hiatus hernia the water test was positive in 2.

Reflux provoked by the water test therefore correlates well with pyrosis, especially in patients with a hiatus hernia. The procedure is readily performed and is well accepted by the patient. It contributes materially to the information derived by roentgen examination of the gastrointestinal tract, particularly in patients with pyrosis.

Clostridium perfringens

SEPTICEMIA FOLLOWING PERFORATION OF A DUODENAL ULCER

HAROLD D. ROSE, MD, and RICHARD J. BUKOSKY, MD, Wood Veterans Administration Hospital and Marquette University School of Medicine, Milwaukee: *JAMA* 198: 1368–1370 (Dec 26) 1966.

Fulminating *Clostridium perfringens* peritonitis and septicemia developed in a 72-year-old man following perforation of a duodenal ulcer. Spontaneous gas gangrene peritonitis arising from the alimentary tract is a rare event. The diagnosis is seldom made antemortem due to failure to suspect clostridia as the causative agent. The criteria for early diagnosis are the following: (1) clinical awareness in a patient with a gastrointestinal lesion in whom an abrupt onset of abdominal pain, distention, fever, and shock develops, (2) evidence of rapid intravascular hemolysis, (3) roentgenographic examination of abdomen showing free air and (4) in any of the above criteria, the finding of large gram-positive rods in the aspirate obtained by peritoneal tap is presumptive evidence of gas gangrene peritonitis.

SELF-TESTING UNIT, SLIDE SET PREPARED ON STROKE DIAGNOSIS

A self-testing unit on "Differential Diagnosis of Stroke" and a set of 36 color slides and accompanying script entitled "The Stroke Syndrome-Pathogenesis," have been issued by the American Heart Association and its affiliates.

The self-testing unit, suitable for table tops, enables from 10 to 15 persons to simultaneously read four case histories and study pertinent laboratory data which are illustrated in four panels. Requiring a space 12 by 16 feet, the unit is intended for use at local or state medical meetings, as a teaching exercise for medical students and house officers, and as a basis for discussion at hospital staff meetings.

The slides briefly review the normal functional anatomy and blood supply of the cerebral hemispheres and brain. Chief emphasis is given to vascular disease processes concerned in the pathogenesis of the stroke syndrome. Non-vascular disease processes which may cause strokes are briefly presented.

Inquiries concerning the testing unit or slide set should be directed to local Heart Associations.

CLEFT LIP

By DONALD M. LEVY, M.D., WILLIAM H. FRACKELTON, M.D.
and JACK L. TEASLEY, M.D., Milwaukee, Wisconsin

■ IN WISCONSIN each year approximately 110 children are born with clefts of the lip and/or palate. This represents an incidence of approximately one patient with cleft lip and/or palate for 812 live births in this state.[1] Of this group of approximately 110 patients 25% have clefts involving only the palate, and the remaining 75% have clefts involving the lip alone or in association with cleft palate.

Etiologic factors which have been implicated in congenital clefts of this nature include genetic variables, drugs, radiation, dietary deficiency, sex, mechanical obstruction in utero, maternal illness during pregnancy, maternal age, and race.

Numerous operations have been designed and described for the correction of these deformities. Time and trial have brought out a number of meritorious procedures relegating numerous other worthy efforts to the category of error.

The purpose of this paper is to present an evaluation of the rotation advancement method of cleft lip repair designed by Millard.[2]

Relative risk values are discussed which will aid in the counseling of parents with cleft deformities or who have children with cleft deformities.

Anatomically there is a great variation in the degree of cleft lip. The clefts may be unilateral or bilateral and can vary from a minimal grooved notching of the lip to the very wide cleft lip with accompanying alveolar cleft, gross nostril deformity, and marked distortion of the maxillary arches. A complete unilateral cleft of the lip extends into the nostril with no bridge of tissue uniting the two sides. Figure 1a shows the normal anatomical position of the orbicularis muscle together with the position of the philtrum and the cupid's bow formed by the vermilion border of the lip. Figure 1b shows a unilateral cleft in which the fibers of the orbicularis muscle can be seen running obliquely rather than horizontally and the well formed but rotated philtrum. Likewise, the central portion of the cupid's bow is present but rotated upwards with the philtrum.

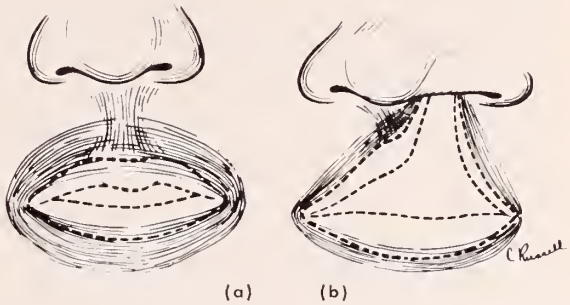

Fig. 1a—Diagram showing normal lip architecture including the cupid's bow, the philtrum column, and the orbicularis oris muscle.

Fig. 1b—Diagram showing altered anatomy in unilateral cleft lip. Note orbicularis oris muscle paralleling the cleft and the rotated philtrum and cupid's bow in the medial segment.

Fig. 2—Millard rotation—advancement, cheiloplasty, incision in medical segment along philtrum border allows rotation of philtrum and cupid's bow into normal position. As the medial aspect is rotated downward, Flap A, Flap B is advanced into defect restoring continuity of orbicularis oris muscle. Flap C is used to lengthen columella and bridge upper part of defect.

Doctor Levy is Instructor in Plastic Surgery, Doctor Frackelton is Professor of Plastic Surgery, and Doctor Teasley is Assistant Professor of Plastic Surgery, Marquette University School of Medicine.

Fig. 3a—Incomplete cleft lip.

Fig. 3b—Six weeks postoperative rotation advancement cheiloplasty.

The main object of any operation on a cleft lip should be to make the whole face look as normal as possible. In order to do this the defect in the lip must be closed with reestablishment of the fibers of the orbicularis oris in their normal position and the normal anatomical landmarks, the cupid's bow and philtrum, must be placed in their normal anatomical position. Also, the widened nasal ala on the affected side must be brought medial-ward and the columella lengthened in order to restore the normal contour to the nose. The rotation advancement flap procedure of Millard as shown in Figure 2 enables the surgeon to rotate the medial segment downward thus placing the philtrum and cupid's bow into a normal anatomical position, and to advance the lateral portion of the lip into a more medial and downward position in order to fill the defect. It can be seen that this procedure approximates the orbicularis oris muscle in its normal horizontal position and at the same time narrows the flared ala and lengthens the columella. The incision thus created falls in the natural line of the philtrum column and the resultant scar is less conspicuous than with other methods.

No emergency exists in the repair of cleft lip although the repair is best carried out within the first few weeks of life. It is preferable to wait until the infant has at least regained its birthweight. Since repair of the cleft lip is an elective procedure, one must wait until the infant is in the best possible health.

The infant with a cleft lip and/or palate can be easily fed using either an oversized nipple or a bulb syringe which has a small rubber tubing attached. Feedings can be maintained indefinitely in this manner if necessary.

TECHNIQUE OF OPERATION

General endotracheal anesthesia is utilized. The rotation incision starts at the potential height of the cupid's bow on the cleft side of the medial element. It ascends along a line symmetrical with the philtrum column on the opposite side and curves directly under the base of the columella. This incision is extended as far as is necessary to drop the dimpled cupid's bow component into normal position and the rotation is facilitated by a tiny cutback if necessary. In the majority of cases, the incision must pass

Fig. 4a—Incomplete cleft lip.

Fig. 4b—Four years postoperative rotation advancement cheiloplasty.

the actual mid-line and should be made on the bias to preserve as much muscle and mucosa in this flap. Flap C now advances into the columella before crossing over as the nostril sill. A minute flap of white skin roll to be used to interdigitate across the scar and maintain an uninterrupted white roll is preserved. Flap A is rotated downward and Flap C is moved upward and laterally. Flap B then moves into the rotation gap with its "white roll" flap ready to fit into a tiny incision in the white roll of Flap A. The alar web in the depressed alar cartilage can then be excised. The edges of the incision are approximated with 6–0 silk. The mucous membrane is approximated with 5–0 chromic catgut.

Following surgery the infant is fed with a Breck feeder for two weeks and the arms are placed in cuffs which prevent the infant's hands from reaching the incision. The sutures are removed on the fifth day following surgery. The infant is hospitalized for one week.

DISCUSSION

The rotation advancement method achieves certain fundamental goals. The entire cupid's bow dimple component is not only preserved but rotated into normal position. Advancement of the lateral upper lip element to the rotation gap not only maintains this rotation but also corrects the alar flare. The method allows for elevation of the columella and preservation of the white line of the vermilion border.[3]

The rotation advancement method of cleft lip repair is useful particularly in the incomplete or complete unilateral cleft.[4] Histologic studies have shown that this method of repair is superior to the methods of Le Mesurier,[5,6] Tennison,[7] Steffensen,[8] and Wynn[9] in restoring the continuity of the orbicularis muscle[10] and placing the resultant scar in the least conspicuous location.[2,11] The advancement rotation method is useful also in the bilateral cleft lip except those which are exceptionally wide in which case the methods of Le Mesurier,[6] Tennison,[7] and Steffensen[8] are useful. A study of 200 cleft lips using the rotation advancement technique has shown excellent results.[12]

In counseling parents who have produced a child with a cleft lip, it is found that their first interest is what can be done to correct the defect both from a cosmetic and a

functional standpoint. The second question that the parents will ask is what is the risk of producing another child with the same disorder. This is a question which the obstetrician, pediatrician, generalist, or plastic surgeon should be able to answer in order to properly counsel these parents. It has been shown by Fogh–Anderson,[13] Broadbent[14,15] and others[16] that cleft lip and cleft lip with cleft palate are genetically similar and are to be differentiated from isolated cleft palate. A family history of cleft formation can be demonstrated in about one-third of individuals with cleft lip and/or cleft palates and in approximately one-fifth of individuals with clefts confined to the palate alone. It is also known that certain nongenetic variables such as maternal age, dietary deficiencies, and the like, can play a part in the etiology of clefts.

Risk values have been derived from the above mentioned values. These values can be used when parents seek genetic counseling.

(1) If a couple with no familial history of cleft lip has a child with a cleft lip, the risk of having a subsequent child with cleft lip is about 4%. The risk of producing a child with cleft palate alone is not greater than for any random birth in the general population.

(2) If a person with cleft lip married a noncleft person and has a child with cleft lip, the risk of having another child with cleft lip is 13%.

(3) If a couple produces a child with cleft palate, the risk of having another child with cleft lip or palate is no greater than with the general population.

(4) If a person with cleft palate marries a noncleft person, the risk of producing a child with cleft palate is about 9%.

(5) If a man with cleft lip married a noncleft woman, the risk of producing a child with this disorder is about 4%.

(6) If a noncleft man who has a brother with a child with cleft lip and cleft palate, the risk of having a child with cleft lip in association with cleft palate is about two to three times the risk in a random birth in the general population.

These values must be used judiciously in genetic counseling. The values represent averages based on many families and it is known that in some families cleft lip and/or cleft palate are strongly hereditary and these families will show an even higher incidence of cleft deformities.

SUMMARY

The incidence of clefts in Wisconsin is approximately 1 in 812 live births and represents about 110 infants yearly born with clefts.

Surgical repair of the cleft lips within the first few weeks of life or when the infant has regained his birthweight is the treatment of choice. In bilateral cleft lip, one side is repaired initially and the remaining side is repaired about six weeks later. In certain cases both clefts can be closed simultaneously.

The rotation advancement technique of cleft lip repair has been shown to give excellent cosmetic and functional results.

The relative risk values in reference to cleft lip and palate are discussed.

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Surgical GRAND ROUNDS NO. 14 OF A SERIES

UNIVERSITY OF WISCONSIN MEDICAL CENTER

Co-Editors:

ROBERT C. HICKEY, M. D.
Professor and Chairman, Department of Surgery

LOUIS C. BERNHARDT, M. D., Resident in Surgery

Surgical Grand Rounds are conducted weekly as a portion of the University of Wisconsin Medical Center program in surgical education. This conference is held at 4 PM on Wednesdays in Room 300, University Hospitals, and guest physician participation is invited. Cases presented at the Grand Rounds will be published in a selective manner periodically in the WISCONSIN MEDICAL JOURNAL.

SHORT BOWEL SYNDROME

Discussants: JOHN R. BENFIELD, M.D.
KENNETH E. LEMMER, M.D.
ROBERT C. HICKEY, M.D.

PRESENTATION

Dr. Joseph Connally: On Nov. 2, 1966, a 19-year-old white man was admitted to the University of Wisconsin Hospitals complaining of sudden onset of severe cramping abdominal pains, followed by nausea and continued vomiting. The pains occurred every 5 to 10 minutes, and were so severe that, while walking to his apartment, the patient had to lie down on the sidewalk to rest. He had had no bowel movements; there had been episodes of vomiting without blood.

His diagnosis on admission was gastroenteritis. At admission, his temperature was 98.0 F. He had mild guarding and tenderness in the upper quadrants of the abdomen; hypoactive bowel sounds were described by one examiner, while another found the abdomen silent. His white blood cell count was 18,500 per cu mm with 72% neutrophils in his differential. His hematocrit reading was 46%. He was given intravenous fluids, and he continued to vomit.

When we were called in consultation, his blood pressure was 70/30 mm Hg, and he was quite pale. At that time, he had a silent rigid abdomen with diffuse tenderness, and his hematocrit had fallen to 34.5%. A diagnosis of an acute abdomen requiring operation was made.

X-ray film obtained en route to the operating room (Fig 1) shows loops of dilated small intestine filled with air. The stomach is obviously dilated.

From the Section of General Surgery.

Preoperatively, the patient was rapidly given intravenous fluids. At exploration, he was found to have a volvulus of the small intestine and a large Meckel's diverticulum. After untwisting the tight volvulus, we measured 15 feet of small intestine from the ligament of Treitz to the cecum. Ten feet of bowel were necrotic and required removal. The proximal point of resection was less than 5 feet from the ligament of Treitz, and the distal resected line was 5 inches from the cecum. Thus, the patient was left with 5 feet of small intestine, exclusive of the duodenum, and including 5 inches of terminal ileum.

Postoperatively, this patient did very well. He experienced some diarrhea after he was started on oral intake, but this was well controlled with antidiarrheal (Lomotil) medication.

DISCUSSION

Dr. John Benfield: Preoperatively, I thought that this patient might have had a perforated duodenal ulcer, and that the distended loops of bowel might represent reflex ileus, perhaps with some mechanical obstruction superimposed upon it. The reason I favored that diagnosis at that time was due to the dilated stomach and very rigid abdomen, board-like, as is classically described in perforated peptic ulcer. However, it was apparent that many things in this patient's history and findings were atypical, that he had an acute abdomen requiring operation, and that the diagnosis would be made at operation.

The Meckel's diverticulum was approximately 30 to 40 cm from the ileocecal valve. There was no band connecting the Meckel's to the anterior abdominal wall. Much as one could suspect it, I do not think the Meckel's

diverticulum can be implicated as an etiologic factor in the occurrence of the volvulus. The point of the volvulus was located some 20 cm from the Meckel's diverticulum.

Dr. Kenneth Lemmer: What were the mechanics of the volvulus?

Doctor Benfield: The mechanics of the volvulus were simply a twist of the mesentery in a counterclockwise rotation. The intestine was essentially tied into a knot. There were no abnormal attachments to the mesentery, which is quite unusual. We made every effort to find an etiologic agent. We thought there might be a band around which the volvulus had occurred, or an internal hernia of the mesentery. We inspected the mesentery very carefully, but there was neither an internal hernia nor attachments of the Meckel's diverticulum to the anterior abdominal wall or to any other point within the abdominal cavity. Arterial pulsations in the mesenteric arcades were excellent after the volvulus had been relieved.

There are several elements of particular interest in this case. The patient was taken to surgery in shock. After removal of the necrotic intestine, his blood pressure became easy to control, whereas previously it had been very difficult. When he awoke in the recovery room, his first comment was, "I feel much better." This is an unusual comment for a patient to make so soon after operation, as generally, patients in the recovery room are having incisional pain and discomfort.

In looking retrospectively at his history, one finds that some weeks prior to the occurrence of this episode, he had had similar abdominal pain, also quite severe, but self-limited. He did not report this at the time of admission. The actual pain which he experienced while he was walking to his apartment was more severe than was apparent; at the time of admission, the vomiting was projectile.

At operation, we unravelled the twist in the mesentery and gave the intestine some time to regain viability, aiming to minimize the length of intestine which would have to be resected. We elected not to proceed with closure of the abdomen and reopening after several hours for three reasons. First, there were five feet of remaining intestine, including five inches of terminal ileum. Second, the patient was in shock, and we felt that the toxins which had been elaborated from this necrotic intestine were harmful to the patient. Finally, we could feel and see excellent pulsations in the mesentery of the gangrenous intestine; and despite the fact that

Fig. 1—X-ray film taken on the way to the operating room.

we waited for a period of 15 minutes with moist room temperature laparotomy pads over the intestine, except for a short segment which regained viability during the observation period, there was no appreciable return of viability. In summary, we felt that it was best not to leave any gangrenous intestine in place, even temporarily, and that the patient would be best served by definitive resection and safe, secure anastomosis. The unusual nature of the obstruction in today's patient, with the volvulus and the rapid progression of his disease, obscured earlier diagnosis by his physicians, despite the fact that he was hospitalized.

Three weeks after operation, the patient visited us in the Outpatient Clinic. He had regained several pounds of weight, and was having bowel movements at a frequency of from three to five times daily. Medication controlled this frequency easily, and he was doing very well. Regarding long-term prognosis, this patient has several factors in his favor. He is young, and there is five feet of small intestine left, including five inches of terminal ileum. He has been able to regain weight during the postoperative period and is able to carry a full schedule of classes. He is scheduled for readmission for absorption studies within the near future.

A related case was reported in 1955 in the *British Journal of Medicine*,[1] concerning a 14-year-old girl who had a volvulus of the small intestine. The summary of this case reads as follows: "The clinical course of a girl who had all but apparently six inches, or 15 cm, of a small intestine resected at the age of 14 years has been described. She has now survived for over 7 years and is in a state of good health and adequate nutrition. She is able to earn her own living and enjoy a reasonable social life. Prompt and careful attention to long term electrolyte losses, especially of potassium and magnesium and calcium, and the administration of vitamin B_{12} seem the most important features of management. Dietary manipulation or additives were ineffective, and difficult to maintain during the long period." Our patient being young, and having considerably more intestine than the patient in this paper, should do quite well, particularly since there is remaining terminal ileum.

Doctor Lemmer: The short bowel syndrome, which we fear particularly in older people, is the problem of not having enough absorptive surface to maintain nutrition. Younger people have the advantage in that they apparently will increase the number of folds or rugae in the remaining small bowel. It is this ability, not present in older people, which allows them to live with a so-called short bowel.

In addition, we have more difficulty with older patients due to other complicating factors. Often they develop a nutritional edema. We had one such patient about 10 years ago. He had a mesenteric thrombosis requiring resection of all but 18 inches of small intestine. He would come in every three months with edema, and we'd have to transfuse him and try to build him up. He finally died of malnutrition.

At that time, we did not know of the reverse bowel segment, which is sometimes used to help these patients. If the patient has insufficient bowel length, you can reverse a segment of terminal ileum of four to six inches, turning it so that peristalsis goes the opposite direction, thus retaining bowel contents for a sufficient time for absorption by the bowel and allowing these patients to maintain a good nutritional status.[2]

Dr. Robert Hickey: By chance, I received a follow-up on a patient I had had some experience with about seven years ago.[3, 4] This patient, at the age of 19 years, was in the Battle of the Bulge in Europe in World War II, and received shell fragment wounds of the left arm and right thigh. Four days later, due to vomiting and severe pain, exploratory laparotomy was performed, presenting with the diagnosis of thrombosis of the superior mesenteric artery. All except 18 inches of small bowel was resected, along with the transverse colon.

I had contact with this patient in approximately 1960, when he was working in mid-Iowa. He had a family, ran a service station, and was completely able to support himself and his family, despite his disability. He managed this by careful diet selection; his intake of food was approximately 6,000 calories per day. On follow-up this week from Dr. William Middleton, who has been in communication with his surgeon, Dr. Herbert Willy Meyer, I learned that this man moved subsequently to Florida, is still in good nutritional status, and in a good socioeconomic status.

I think that the point has been well made that today's patient has a fairly good out-

look. There is a small portion of the distal ileum remaining, the ascending colon is present, with five feet of small bowel proximally, and he is young.

Editorial Comment: Three months postoperatively, complete absorption studies were performed. The results were as follows:

(1) Schilling test with intrinsic factor 4.4% absorption in 24 hours, normal being greater than 10%, and pernicious anemia patients having less than 1% to 2%.
(2) Xylose absorption after a 25 gm oral dose, 2.2 gm in five hours. This is normal.
(3) On a 72-hour, 100-gram fat diet, the fecal fat output was 9.7 gm per day for a coefficient of fat absorption of 0.903, normal being 0.900. Therefore, fat absorption was only slightly decreased.
(4) Serum carotene 40 mcg per 100 ml, normal ranging from 50 to 150.
(5) Prothrombin time 12.8 seconds with a control time of 12.0 seconds.
(6) Total protein 7.5 gm per 100 ml, including 4.5 gm of albumin.
(7) Serum cholesterol 98.

The patient gained weight rather rapidly, weighing 136 pounds at discharge from the hospital and 152 pounds three weeks later. The most recent weight recorded is 147 pounds. He is carrying a full load of classes, and we anticipate that he will do well. We are planning to supplement him with monthly injections of 100 mcg of vitamin B_{12}.

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WISCONSIN'S HEALTH by E. H. JORRIS, M.D., State Health Officer

"END MEASLES" DRIVE STARTED IN APRIL

Red measles can be wiped out in Wisconsin. Giving impetus toward this goal is the purpose of the "End Measles" immunization education program that began April 1 under the sponsorship of the Wisconsin Jaycees and the Wisconsin Association for Retarded Children.

The objective of the campaign, as stated in the fact sheet sent to each county chairman, is "to reach every family in your county with the facts about measles and the news that the vaccines are easily available and to get them to consult their physicians."

How serious is measles?

In Wisconsin, and in nearly all states, it is the most prevalent reportable disease. There were 30,775 cases of measles reported to the State Board of Health last year. In the seven calendar years since Jan. 1, 1960, there have been 235,687 cases of measles in Wisconsin. In those seven years there were 49 deaths due to measles.

No one knows how many youngsters are going through life with handicaps as a result of red measles. It is estimated that one in every 15 children who have measles may develop a potentially serious complication such as pneumonia, bronchitis, ear infection, corneal ulcers, or neurological disturbances. The most dreaded complication is encephalitis, which can result in mental retardation.

In November of 1966 a series of immunization clinics were held throughout Columbia County after the project had been initiated by the local medical society in conjunction with the Columbia County Nursing Service. A survey had shown there were 3,000 boys and girls in the county that were susceptible to red measles; 2,695 were vaccinated at the ten clinics that were held.

Since that first countywide program physicians and public health workers have put on similar immunization campaigns in several counties and cities. At least a dozen other counties are presently considering initiating immunization programs. The Jaycees and the Wisconsin ARC may well provide the extra incentive to encourage enough activity to place measles under control in Wisconsin.

The State Board of Health is able to provide measles vaccine for preschool-age children to be administered either in a physician's office or at immunization centers. We can also provide measles vaccine for school-age children at community immunization clinics. The local health officer and local public health nurse have the details.

* * *

THE NUMBER OF veterans hospitalized for emphysema and chronic bronchitis, lung diseases common to the aging, has more than doubled in eight years, the Veterans Administration reports.

Drug Therapy in Pregnancy

By DOROTHY M. BARBO, M.D.
Milwaukee, Wisconsin

■ THE THALIDOMIDE TRAGEDY has done much to make the public aware of the vulnerability of the fetus in utero. The alert physician is still the prime factor in the defense of the fetus. The obstetrician must be aware of medications his patient receives in utero. Stresses undergone during the prenatal period and birth may greatly affect the newborn's ability to detoxify and excrete substances such as bilirubin and drugs.

A physician must know the effects of the drugs he prescribes. He must always consider early pregnancy when treating any female in the childbearing age. He should warn his patients (and his own family) regarding nonprescribed medications in pregnancy.

The placenta as an organ of transfer has two independent circulations—fetal and maternal. The intervillous space is filled with maternal blood at all times. It is the depot of transfer which supplies the fetus with nutriments. It also serves as the organ of elimination for the fetus which the lung, gastrointestinal tract, and kidney fulfill in extrauterine life.

The chorionic villus is the agent of transfer containing blood vessels of the fetus. The placenta accommodates itself to increasing demands of the fetus by alterations in architecture of the chorionic villi. It increases the surface area of villi in maternal blood by an increase in number and in fetal capillaries and by a thinning of the villous coat. Substances in the maternal circulation must pass through the trophoblast of the villus, the stroma, and the wall of the capillaries to reach the fetal circulation.

A classification of methods of transfer across the chorionic villi was outlined by Page: rapid diffusion, active transfer and diffusion, slow diffusion, and pinocytosis. Factors controlling diffusion of any substance are largely those of Fick's law and are dependent upon:

(1) concentration gradient,
(2) degree of ionization (pH 4.3 to 8.5 and the undissociated or non-ionized form of the drug favoring transfer),
(3) lipoid solubility,
(4) surface area and thickness of the membrane, and
(5) molecular weight.

Substances of molecular weight below 500 diffuse freely. As size increases, the lipoid solubility is important. Substances between 600 to 1000 molecular weight have been poorly studied for transfer across the placenta; those over 1000, it is virtually impossible to pass except by pinocytosis and leaks. In high concentrations some substances will cross. Molecular weight at times appears to be no barrier if there is selective transfer.

Pathologic changes may weaken or eliminate the selectiveness of the placenta as: pre-eclampsia or eclampsia, erythroblastosis, diabetes mellitus, maternal asphyxia, hypotension, dehydration or hemorrhage. Uterine blood flow may vary with contractions, anesthesia (hypotension), and maternal position. Vitamin or nutritional deficiency of the mother also play an important role.

Maternal renal or liver failure may prevent excretion or detoxification so that levels of a substance become excessive. The effect on the fetus of a drug will vary with:

(1) dosage
(2) route
(3) duration
} of administration,
(4) age of fetus, and
(5) nutritional and health status of the mother.

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COMMENTS ON TREATMENT

Presented through the cooperation of the Department of Pharmacology, Marquette University, Milwaukee, and the Department of Medicine, University of Wisconsin, Madison

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The pharmacologic action of drugs may be altered by concomitant use of certain agents by summation, potentiation or antagonism.

Teratogenic effects occur largely in the first trimester when the fetus is forming organs and systems. A knowledge of embryology allows one to determine within an accuracy of two to three weeks the time in development when the insult occurred, but rarely the etiology. Sexual ambiguity of the female fetus has become prevalent with many new and varied hormonal preparations on the market, especially progestogens and androgens. Well known teratogenic agents are thalidomide, testosterone, methotrexate, and aminopterin.

Drugs given prior to delivery may cause problems for the newborn. Absorption, biotransformation, and excretion of chemicals often do not follow adult patterns due to organ immaturity. The liver at birth lacks enzymes which detoxify substances; they are usually adequate by four weeks of extrauterine life. Glucuronyl transferase is necessary to detoxify and excrete bilirubin, sulfonamides, chloramphenicol, or vitamin K analogues. The kidney has a low clearance capacity for organic acids. An excess of any one or a combination of substances may be more than the infant can handle and damage to tissue may result.

BARBITURATES

The barbiturates in general and the ultrashort acting thiobarbiturates specifically cross the placenta almost immediately and attain equilibrium between the circulations in a few minutes. Their chemistry is instructive in that they are weak acids occurring largely as fat-soluble undissociated molecules in the physiologic range of pH, making them ideal substances to cross. Moderate dosages are safe for analgesia; neonatal respiratory depression is dependent on dosage and time of administration. Anesthetic dosages are still uncertain as to total fetal effect.

TRANQUILIZERS AND SEDATIVES

The phenothiazine family including chlorpromazine (Thorazine), prochlorperazine (Compazine), promazine (Sparine), perphenazine (Trilafon), trifluoperazine (Stelazine), and promethazine (Phenergan) passes the placental barrier readily. Effects on infants are not well correlated or studied. It is reported that they reduce the amounts of barbiturates and narcotics needed in labor. They are not recommended in patients with incipient eclampsia or epilepsy. Thalidomide is not used in pregnancy; it may be a folic acid antagonist; it forms glutaric acid instead of glutamic which has a rapid turnover in developing fetal tissue. While glutethimide (Doriden) resembles thalidomide in structure, its metabolism is by oxidation like the barbiturates rather than hydrolysis as is thalidomide. Reserpine causes recognizable side effects in 10% of infants for up to five to six days after birth—nasal congestion, lethargy, decreased briskness of the Moro reflex, bradycardia, excessive secretions, and decreased thermal stability. Chloral hydrate and paraldehyde may cause some fetal depression with high concentrations. Paraldehyde may be detected on the infant's breath two to three days after birth. Ethyl alcohol crosses the placenta but infants are not depressed in inebriated mothers. Monoamine oxidase inhibitors are slowly excreted. Because of their general enzyme-inhibiting properties, MAO inhibitors may interfere with detoxification of drugs which prolong and intensify the actions of central depressant agents such as: alcohol, barbiturates, potent analgesics as meperidine (Demerol) and morphine, antidepressant agents as imipramine (Tofranil) and amitriptyline (Elavil), and anticholinergic agents especially those used for Parkinsonism. Other commonly used drugs are: isocarboxazid (Marplan), nialamide (Niamid), phenelzine sulfate (Nardil), tranylcypromine (Parnate). Frequently a physician may be unaware that the patient is taking these drugs which have been prescribed by another physician.

NARCOTICS

All cross but rates of transfer are not well known. The time and routes of administration are important. Depression of the infant may be additive to anesthetic agents. Neonatal abstinence syndrome in babies whose mothers are addicts is a threat to the newborn's life unless recognized and treated. The newborn may exhibit progressive restlessness and irritability with high-pitched crying. They feed poorly and may vomit; cyanosis, diarrhea, lacrimation, diaphoresis, and salivation may occur as well as tremors and convulsions. Symptoms usually vary with the degree of maternal addiction. The narcotic antagonists are mild narcotics themselves and readily cross the placenta. Ade-

quately controlled double-blind studies have not been done to evaluate these drugs.

BELLADONNA ALKALOIDS

Atropine and scopolamine readily cross the placenta within 15 minutes of intravenous administration and 30 to 60 minutes of intramuscular. Fetal tachycardia may occur. Scopolamine is not recommended in toxemia of pregnancy as central nervous system excitation may occur.

GASEOUS AND VOLATILE ANESTHETICS

All of these drugs transfer rapidly across the placenta by rapid diffusion because of high fat solubility and low molecular weight. Cyclopropane concentration in the fetus equilibrates with maternal levels in about five minutes. Neonatal narcosis is proportionate to depth and duration of maternal anesthesia; other sedatives and analgesics increase fetal depression. Agents which are good uterine relaxants may also cause uterine atony and hemorrhage with deep anesthesia for version and extraction, manual exploration, or Cesarean section—cyclopropane, halothane (Fluothane), methoxyflurane (Penthrane), ether, and the like. The local anesthetic agents may be dangerous if intra-arterial, intravenous, or fetal intracranial injection occurs.

NEUROMUSCULAR BLOCKING AGENTS

Drugs used as muscle relaxants as adjuvants to other anesthetic agents include tubocurarine chloride, gallomine triethiodide (Flaxedil), decamethonium iodide and succinylcholine chloride (Anectine). These drugs have a single common feature—a quaternary ammonium group which is highly ionized and has low lipid solubility. These drugs are known to cross the placenta only if high concentrations are used; fetal problems have not been reported. Provision for adequate maternal ventilation is essential.

ANTIBIOTICS

All antibiotics studied cross the placenta; with most, bacteriostatic concentrations are found in the fetus following maternal administration.

Penicillin gives good fetal levels. Concentrations may equal or exceed the maternal with continuous intravenous infusions or the long-acting forms. It is probably the safest antibiotic for use in pregnancy.

Ampicillin is more effective against certain Gram-negative bacteria than other penicillins. It is not recommended as a substitute for penicillin G nor is it a broad spectrum antibiotic, but it is certainly preferable to some others in pregnancy. No problems have been reported.

Streptomycin levels are 50% of maternal levels. Eighth nerve deafness has been reported in a small percentage of newborns regardless of dosages or age of the fetus when administered; these may be unusually susceptible individuals.

Sulfonamides cross the placenta readily with equilibrium in three hours. The long-acting forms should not be used in pregnancy due to fetal levels which the newborn may have difficulty excreting; hyperbilirubinemia may occur.

Chloramphenicol fetal levels equal maternal. The drug is no problem to the fetus in utero. If at delivery the newborn has substantial levels, the immaturity of the liver may prevent detoxification and excretion. Toxic concentrations appear to inhibit protein synthesis including enzymes. The "gray-syndrome" which includes abdominal distention, progressive pallid cyanosis, shock, and death is well known. Prematurity increases the severity of the problem in the newborn.

Isoniazid gives equal fetal levels within 15 minutes of maternal administration; at times fetal levels may exceed maternal.

Tetracyclines are contraindicated in pregnancy and infancy. They have an affinity for deciduous and permanent teeth and may cause permanent discoloration. It selectively deposits in the epiphyseal areas of long bones, and slowing of bone growth has been reported. The deposition of the drug in teeth and bones is probably due to its chelating property. In young infants given the usual therapeutic doses, increased intracranial pressure and tense, bulging fontanels occur. Hepatic damage has been reported; in pregnant women there have been severe problems and deaths. Renal dysfunction interferes with excretion. These drugs are excreted in the urine and feces via bile. Tetracyclines include chlortetracycline (Aureomycin), oxytetracycline (Terramycin), tetracycline (Achromycin V, Panmycin, Tetracyn), and demethylchlortetracycline (Declomycin).

Nitrofurantoin (Furadantin) is useful in treating urinary tract infections when the organism is not sensitive to the more com-

monly used drugs. Gastrointestinal side effects are frequent. Excessive doses may cause hemolysis in the newborn. It is contraindicated in patients with glucose-6-phosphate dehydrogenase deficiency or renal insufficiency.

The safety of the following drugs in pregnancy has not been established: cycloserine, lincomycin, nalidixic acid (NegGram), novobiocin, and sodium cephalothin (Keflin).

ANTICOAGULANTS

Heparin is the drug of choice; it is a large molecule which does not cross the placenta. Its effects are readily correctible with protamine sulfate. Bishydroxycoumarin (Dicumarol) and warfarin (Coumadin) cross the placenta and may cause fetal death from hemorrhage or hemorrhagic obstetrical complications even if the mother's prothrombin time is well controlled.

ANTIMETABOLITES

These agents because of their fetal effects are contraindicated in the first trimester of pregnancy unless necessary to save the life of the mother. If these drugs are used, termination of the pregnancy may be indicated. The damaging fetal effects of aminopterin and methotrexate are well known.

ANTIPARASITIC

Antimalarial agents should all be used with caution. Quinine crosses the placenta but has not been a problem in the usual clinical doses. It is a weak oxytocic agent. Primaquine is contraindicated because it may cause acute intravascular hemolysis, especially in races which lack glucose-6-phosphate dehydrogenase; all newborns lack this enzyme. Pyrimethamine (Daraprim) is a weak folic acid antagonist; large doses should be avoided in the first trimester. Metronidazole (Flagyl) used in treating trichomonas transverses the placenta readily; since the fetal effects are unknown it is contraindicated in pregnancy, central nervous system (CNS) disease, or with a history of blood dyscrasia. Emetrin for amebiasis is contraindicated because of serious side effects. For pinworms pyrvinium pamoate (Povan) is safe; it remains in the gastrointestinal tract except in minute amounts and has few side effects. Piperazine may be used with caution for round or pinworms.

ANTIHISTAMINES—ANTIEMETICS

The nonphenothiazine antiemetics are preferable and generally safer than the phenothiazines, although they may not act as quickly. Serious side effects of antihistamines are drowsiness and potentiating effects of other CNS depressants. No anomalies have been reported in the human. High doses of the vitamins B and C, especially pyridoxine hydrochloride are usually effective for control of "morning sickness." Preparations in use are diphenhydramine (Benadryl), dimenhydrinate (Dramamine), and cyclizine (Marezine). Chlorpheniramine (Chlor-trimeton or Teldrin) is also useful for allergic conditions.

ANTIHYPERTENSIVES

Methyldopa (Aldomet) is not currently recommended in pregnancy because lactation and breast engorgement may occur. Ganglionic blocking agents may produce parasympatholytic effects of atony of bladder and bowel, especially at the time of delivery or surgery and in the newborn. Ileus and pneumonitis are increased in infants whose mothers receive chlorisondamine. Rauwolfia alkaloids may cause nasal congestion and drowsiness in the newborn.

ANTI-INFLAMMATORY AGENTS

Excessive doses of salicylates may cause neonatal bleeding. The therapeutic usefulness of enzymes has not been established.

ANTITHYROID DRUGS

Drugs such as the iodides (KI), propylthiouracil, and methimazole (Tapazole) all readily transverse the placenta. All can cause a goiter in the fetus by blocking fetal production of thyroid; the goiter may obstruct the newborn airway. These drugs should be used in the lowest dosage possible to control the maternal disease, and decreased prior to delivery. It is beneficial to add 60 to 120 mg of thyroid daily for fetal protection, since it is thought to cross the placenta. I^{131} is contraindicated for diagnosis and therapy in all pregnant patients. It readily crosses the placenta and is concentrated in the fetal thyroid as early as 12 to 14 weeks gestation and damages or may even destroy the function of, the fetal gland.

ANTITUSSIVES

Codeine preparations are the most useful of these agents available. The newer preparations have not had sufficient evaluation in pregnancy and the newborn.

RADIOACTIVE SUBSTANCE

The placenta is highly permeable to low-molecular weight chemicals including those of isotopes or tagged compounds as: I^{125}, I^{131}, P^{32}, Ca^{45}, Na^{22}, Co^{60}, S^{35}, Sr^{89}, Sr^{90}, Cs^{137}, Fe^{59}, or Zn^{65}. All of them will reach, lodge within tissues of, and affect the embryo or fetus. Radioiodinated serum albumin (RISA) has been used in placental localization with relative safety. A blocking dose of iodides is given to the mother first. The serum albumin is a large molecule which does not cross the placenta under normal conditions.

DIURETICS

Thiazides and related compounds cross the placenta and should not be used indiscriminately until more is known regarding effects on the fetus and newborn, especially in the first trimester. Adverse reactions are electrolyte imbalance, photosensitivity, elevated uric acid levels, a rare blood dyscrasia, aggravation of preexisting diabetes, and neonatal thrombocytopenia. Hyponatremia and hypokalemia may be serious as may depletion of extracellular fluid volume. In toxemia of pregnancy the extracellular fluid or blood volume may be markedly reduced to dangerous levels while the intracellular or interstitial volume remains immobilized. These drugs have little or no effect on hydraminos. If severe electrolyte imbalance occurs, especially hypokalemia, oliguria or renal failure may develop. These drugs should be given in an interrupted pattern to allow the patient time to restore his potassium balance if long-term therapy is necessary.

The newer drugs as ethacrynic acid and furosemide (Lasix) are four times as potent as thiazides and are not recommended in pregnant patients. Diuresis begins within a few minutes of administration and may be massive.

Ammonium chloride may cause acidosis with prolonged use. Carbonic anhydrase is not as effective as the thiazides. Mercurials are not recommended in pregnancy.

HORMONES

Progestins have mild androgenic properties and may cause multiple genitourinary malformations of the female fetus, especially norethindrone (Norlutin) or norethindrone with mestranol (Ortho-Novum, Norinyl). Androgens, especially methyltestosterone, cause masculinization of the female fetus and advanced bone age. Many of the anabolic agents contain androgens.

VITAMINS

Excessive doses of the vitamin K analogues may cause hyperbilirubinemia if the newborn liver cannot conjugate them adequately. Excessive doses of vitamin D may produce a syndrome of supravalvular aortic stenosis, mental retardation, peculiar facies, and idiopathic hypercalcemia.

HYPOGLYCEMIC AGENTS

Insulin is the drug of choice as it effectively handles hyperglycemia. The oral agents all cross the placenta; they are NOT recommended in pregnancy since the long-term effect on the fetus, especially pancreas, is not known. Phenformin (DBI) is unsuitable since it increases tissue lactate production and decreases oxygen consumption. The sulfonylurea derivatives have caused anomalies in animals but not in humans. Chlorpropamide (Diabinese) may cause excessive maternal hypoglycemia—a threat to the fetus. Perinatal deaths of 65% were reported in one series due to respiratory and hemorrhagic causes. To date few problems have been reported with tolbutamide (Orinase) but the long-term effects are unknown.

INTRAVENOUS FLUIDS

Excessive amounts of hypotonic or hypertonic fluids will cause marked shifts across the placenta causing electrolyte imbalance and dehydration or overhydration in the fetus.

LACTATION

Lactating patients should be treated with the same precautions since nearly all substances which the mother ingests are excreted into her milk in some form from low to high concentrations. This should not in any way discourage breast feeding except when a medication is vital to the mother's health. It is strongly recommended that un-

necessary medication be withheld during lactation.

SUMMARY

The lack of a reliable experimental animal has made it difficult to evaluate the safety of drugs for the human fetus. Many animal experiments are not transferable to the human. All new drugs must be used with the utmost care in light of present knowledge of pharmacology.

In the critically ill pregnant patient a drug known to be beneficial should not be withheld if the mother's life is in jeopardy.

The alert clinician is still the prime factor in defense of the fetus. He is aware that any substance which exists in the maternal circulation could reach the fetus in some quantity with given conditions.

Basic rules for medications in pregnancy are:

(1) Prescribe only well tried drugs.
(2) Avoid drugs in the first trimester unless urgently needed.
(3) Keep an accurate record of time, duration, and dosage of all drugs prescribed.
(4) Correlate abnormalities in the fetus with drug administered to determine if they could have been causative.

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AORTIC OBSTRUCTION ASSOCIATED WITH METHYSERGIDE MALEATE THERAPY FOR HEADACHES

James E. Conley, MD, Wayne J. Boulanger, MD, and Gale L. Mendeloff, MD, Department of Surgery, Columbia Hospital, and Marquette University School of Medicine, Milwaukee: *JAMA* 198:136–138 (Nov. 21) 1966.

Methysergide maleate (Sansert) and compounds of the ergot type have been associated with fibrous changes and obstruction of large as well as smaller arteries. The prolonged use of methysergide maleate therapy for migraine has been associated with retroperitoneal fibrosis causing ureteral obstruction. The first known case was reported of an obstruction to the abdominal aorta and iliac arteries associated with methysergide therapy. The report is documented by laboratory vascular studies and aortograms performed during the period of obstruction and after a suitable period following cessation of the drug when the symptoms had subsided.

The patient was a 61-year-old white woman who was incapacitated by intermittent claudication in both lower limbs with pain which she referred to the gluteal and the thigh regions. The abnormal initial findings were absent arterial pulsation including the femoral in both lower limbs. The discontinuation of the migraine therapy was followed by regression of the retroperitoneal fibrous process, and complete relief of her symptoms followed within two months after discontinuation of the therapy.

Methysergide maleate and all members of the ergot family of drugs should be used with caution and as directed. Follow-up examination should be performed frequently because of the possible effect of such drugs upon the wall of the large blood vessels. A marked thickening may develop in the media and outer layers of a major artery causing narrowing of the artery lumen and the encroachment by the dense fibrous tissue upon structures such as the ureter adjacent to or contiguous with large arteries. The treatment of large artery stenosis associated with methysergide maleate therapy is the prompt cessation of the therapy for the migraine.

THYROID CARCINOMA AFTER RADIATION THERAPY FOR ADOLESCENT ACNE VULGARIS

Edwin C. Albright, M.D. and Robert W. Allday, M.D., Department of Medicine, University of Wisconsin Medical School, Madison: *JAMA* 199:128–129 (Jan 23) 1967.

Roentgen therapy has been used for many years in patients with adolescent acne vulgaris. Without proper shielding of the neck the thyroid gland may receive undetermined amounts of irradiation. The potential carcinogenic effect on the thyroid has been largely ignored by the therapist in this group of patients, although the association of thyroid cancer and irradiation to the thymus in infancy is well recognized. The purpose of this report is to call attention to the possible hazard of thyroid cancer after radiation therapy for acne vulgaris. Five adult patients with thyroid cancer, in whom it was possible to obtain a history of radiation therapy for acne vulgaris in adolescence, have been seen. Because a causal relationship between incidental radiation to the thyroid and carcinogenesis cannot be disproved, radiation therapy for acne and other benign diseases of the head and neck should be abandoned in the adolescent patient.

THE PRESIDENT'S PAGE . . .

FRANK E. DREW, M.D.
Milwaukee

Resumé

■ ALMOST A YEAR has passed since I accepted the very great honor which you bestowed on me. I pledged to you to exercise every effort to defend the high principles of the practice of medicine, to communicate with you, and to try to offer help and solution to the most complex and trying times in the history of medicine. It is my sincere hope that my efforts have been in keeping with the fine tradition of my predecessors, and the physicians of this state who so generously help with their time and efforts to make the house of medicine secure and worthy of its membership.

For your welfare I have sought justice, advice, and prosecution of the high ideals of our profession. I have to the best of my efforts given all these causes and problems a full measure of consideration.

This past year will enter the archives of history with a dually significant record—the recording of the 125th anniversary of the founding of the state medical society—the many celebrations of historic events and the records to leave for posterity to pay tribute to these milestones in the march of medicine. Worthy recognition has been paid to this historic event. The second event of the year was the greatest change in the history of medicine—the advent of the third party in the daily practice of medicine. This is something we tried to prevent, but now it is a reality and the law of the land. The terms of defeat are now being exacted through directives and guidelines. Fortunately because of the foresight of my predecessors in the field of society-operated medical insurance we were able to absorb the impact of these new problems with minimum disturbance. We had an organization with experience in health fields and when we were designated to carry out the Medicare programs and problems we were being complimented for our previous efforts. Many states were not so fortunate to have a medically oriented Governor and State Board of Health to place this high confidence in their societies.

We do control our destiny with some degree of assurance, but this would not be the case if we had a third party leading us down the path of uncertainty. The ultimate outcome of the course of these new programs will rest entirely on the shoulders of the medical profession. By wisdom, courage, and fortitude we can resist the inroads of dissemination of professional activities and our lives. Capitulation will lead to destruction and can only result from the lack of concerted action, cooperation, and efficient management.

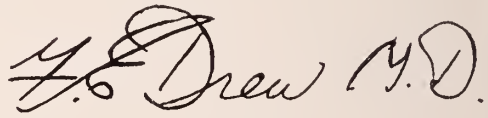
We must always be vigilant to the processes which would destroy the philosophy of medicine as we now practice it. We must not permit the practice of medicine to become a system of paid physicians operating under the control of a university hospital or institution. The captive physician will sacrifice his rights and dignity and will be caught in a pincer movement that will force the private practitioner and family physician into oblivion. The old practice of dividing and destroying and using the tactics of favoring segments of our profession seems to be the policy of the new approach to the practice of medicine. No group should be allowed by any means to capture or segment our profession. Only united effort will deter such processes and no branch of medicine should stand alone in this struggle. The impact of the recently enacted legislation has made itself felt not only in the cities but also the rural areas. It has become imperative now that physicians not only participate in elections and issues but also support candidates and even seek office at all political levels. Representation now is mandatory.

PRESIDENT'S PAGE *continued*

What is enveloping us now can be controlled only by strong political action and exertion of our influence in the directives. Your failure to do your duty as a citizen will allow the government to become a more deadly instrument. Government is not a substitute for people. The federal government through the control of universities, medical schools, and hospitals is now molding and shaping the pattern of health care of the future in this country, and the future appears dismal if we are derelict in our actions and duties.

I have as your president attempted to attract your attention to the problems of the future and assess the dangers and damages that can result. This trust that you placed in me will be of little service or benefit to you unless I stress these factors and you rise to the occasion. There shall be no compromise in principles or lack of willingness to recognize these developments. Freedom is lost by indifference and is eventually destroyed. Medicine has its opportunity to make freedom and survive. We are equal to the task!

I want to thank you again for the honor bestowed upon me, and I hope that I have been worthy of your confidence. I have tried to represent you on all levels and fields of endeavor. I have been sincere in all my efforts, but declamations sometimes are not understood and neither is the most popular form of administration. I can assure you that regardless of the implications your interests were always paramount. I shall always be ready and willing to continue to serve the field of medicine and my fellow practitioners. If I have stimulated physicians to continue on, then my rewards have been amply satisfied.



THE CHARITABLE, EDUCATIONAL AND SCIENTIFIC FOUNDATION was founded in 1954 to permit physicians and friends of medicine an opportunity to sponsor projects affecting the health of Wisconsin citizens.

Among the many projects which are supported by this method is the Medical Student Loan Fund. Since the integration of the loan fund into the Foundation in 1955, the student loan aspects of the program have grown.

Every practicing physician recognizes the unquestionable need for timely aid to the kin of his profession who face unusual financial hardship. Personal hardship strikes at physicians and their families as well as others. Through the Foundation there is an opportunity for professional persons to assist their colleagues who suffer adversity.

The Scientific medicine activities of the Foundation include circuit teaching programs, speakers service for county medical societies, and the support of research in many fields in cooperation with other agencies.

The Foundation has not neglected the value of learning from the past and the Museum of Medical Progress and Stovall Hall of Health, reconstruction of the Fort Crawford Hospital in Prairie du Chien, have made many visitors aware of the role that medicine has and is playing in their lives.

The voluntary contributions recommended by the House of Delegates is being supplemented by many physicians and others who find in the Foundation an opportunity for special gifts. Gifts may take a number of forms such as cash, life insurance, securities, books, old medical instruments, stamp and coin collections, works of art and other artifacts. Some physicians are making the Foundation a beneficiary in their wills. Gifts may be unrestricted, permitting the Trustees to use the funds for any purpose for which the Foundation was created. They may also be restricted or earmarked for specific purposes of interest to the donor. In any event, all contributions to the Foundation are deductible for income tax purposes.

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EDITORIALS

D. N. GOLDSTEIN, M. D., *Editorial Director*

Report to the President

■ ANY WAGE-EARNER with a family could have told President Johnson the same story: the cost of medical care is getting so high that it is putting a real financial burden on those who have to pay for it. But a study conducted by the U.S. Department of Health, Education and Welfare, the Labor Department, and the President's Council of Economic Advisors made it official in a preliminary draft of *A Report to the President on Medical Care Prices*. The verdict: "The price of medical care is rising faster than in the past and faster than other prices."

One of the reasons for the increase was the sharp advance in physicians' fees during the first part of 1966. Between 1950 and 1965, doctors' fees rose at the rate of about 3% per year. In the first nine months of 1966, the advance was 6.1%. The Report attributes this rise to the fact that the demand for physicians' services is increasing faster than the supply. This heightened demand was produced in part by a 28% increase in population between 1950 and 1965, as well as a 34% increase in per capita disposable income. It isn't that individual doctors have been skyrocketing the fees for their service, the Report concludes, but that "the major impetus for movement in the Consumer Price Index for physicians' fees came from the fact that more physicians were adjusting their fees than in earlier periods, not from larger percentage adjustments."

The cost of hospital care was the second major component which increased the cost of health care. In the period between 1950 and 1965, it went up more than 13%. Some of the increase is not surprising, given the tightening labor market, the increasing demand for hospital services and other nonhospital-connected reasons. However, one of the key factors in rising hospital costs, according to the Report, was inefficiency.

Unlike competitive enterprises, the Report indicated, hospitals lack incentive to be efficient. Patients are obviously not in a position to exert any significant pressure by way of protest at rising costs, and many times they are unconcerned because their bills are paid by insurance companies. Hospital administrators, the Report says, generally lack the training for effective management and even when they have the capability and where the incentive does exist.

the possibility of cost-reducing innovation is often beyond the resources of individual institutions. And so, since all the hospitals of a community are in the same boat, the patient can do nothing but submit to the gouge perpetrated by inability, indifference. and inefficiency.

The Report makes a number of sensible suggestions: it recommends that the federal government encourage alternatives to hospital care, institute areawide planning for health services, and increase the supply and improve the utilization of health care manpower. It urges the establishment of a National Center for Health Services Research and Development in the U.S. Public Health Service which would offer technical assistance and financial support in the development of model medical care systems at the local level.

To put a brake on the increase of cost of physicians' services, it suggests that mechanisms be worked out to stretch the coverage of such services, such as new types of organizational structures and new types of personnel that would relieve the physician of duties that individuals with less training could perform under the physician's supervision.

To stop the spiral of hospital costs, the Report recommends "the development, demonstration and implementation of cost-reducing technological innovation and methods of reorganizing the delivery of services in hospitals." But more important, it urges that the reimbursement formula used in Medicare and Title 19 be reconsidered. Specifically, it suggests alternative payment plans, including those in which some incentive is given for cost reduction. For example, a fixed-price approach would compel an institution to price its services in advance and make or lose money in proportion to its ability to control costs.

The Report deals exhaustively with a complex subject. Undoubtedly the Report prefigures additional federal involvement in local health care situations. In fact, a central recommendation of the Report is that the federal government assist the states in planning the distribution and rate of expansion or retraction of health facilities in the community by providing funds for such planning bodies and by denying federal support to health institutions that refuse to comply with the reasonable directive of such planning bodies.

It doesn't take too much foresight to see what this federal involvement will bring: more red tape, more forms, more administrative detail, and ultimately a higher cost of medical service shifted to the general tax burden rather than applied directly to the patient.

The Report is a good one, nevertheless, for the warning it gives. Perhaps we can put our own house in order before Uncle Sam steps in swinging his money-bag. Perhaps we can effect the efficiencies—and convince the hospitals to make greater effort to reverse their ruinous course of devil-may-care price hiking. Hopefully we can make use of the Report for its reasonable suggestions rather than assume a posture of deploring and regretting as the freedom of our practice slips away from us.—D.N.G.

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Relapsing Polychondritis

Report of a Case

By LAURENCE G. CROCKER, M.D., Madison, Wisconsin

■ RELAPSING POLYCHONDRITIS is the diagnosis given to a syndrome of inflamed ears and nasal cartilages, polyarthralgia and arthritis with effusion, and inflammatory changes of other cartilages including the larynx, trachea, epiglottis, ribs, thyroid, bronchi, and eustacian tubes.[1] The involved ears are swollen and painful, have been described as "beefy red" and can become deformed. Destruction of the nasal cartilage has led to saddle-nose deformity. Other lesions accompanying the syndrome have been ocular inflammation and proptosis, inner ear involvement with auditory impairment and vertigo, and a generalized systemic reaction including weight loss.[2]

The prominence of inflammation in the nonarticular cartilages rather than in the joints is what sets this syndrome apart. However, when the joints are involved they resemble rheumatoid arthritis and can be a cause of disability. The illness is chronic and is marked by exacerbations. Destruction of tracheal cartilages with collapse has resulted in fatalities.[3] The histopathology shows chondrolysis.

The reported laboratory studies have been nonspecific, but usually include an elevated erythrocyte sedimentation rate, a negative LE cell preparation and a negative-to-slightly-positive latex agglutination. Treatment has been supportive and includes corticosteroid therapy.

Thurston's recent review of the literature and case report brought the combined total of reported cases to 44.[4] These cases have been spread throughout the many specialty journals including those of dermatology, ophthalmology, otolaryngology, orthopedic surgery, and medicine.[1-6] It was the appearance of Kaye's report during the study of the present patient that led to the diagnosis in this case.[6] This patient's illness was typical in most regards. It was complicated by an occlusion of the right cochlear artery which caused a disabling unsteadiness and led to his medical retirement.

CASE REPORT

The patient was a 57-year-old engineer who was hospitalized for dizziness and tinnitus in March 1964 under the care of an otolaryngologist. There had been a similar self-limited episode of dizziness five months before. During the three years preceding admission, he had tired easily, had lost 30 lb, had had one to two day episodes of inflammation in his large joints and costal cartilages and in his right eye. The right ear drum had been lanced 40 years before.

His physical examination was normal except for a scarred right ear drum, and showed no inflammation of the joints. A urinalysis was normal. His hemoglobin level was 13.3 Gm per 100 ml, hematocrit reading 45.5%, leukocyte count 14,200 per cu mm, with a differential count of 77 neutrophils, 19 lymphocytes, 2 monocytes, 1 eosinophil, and 1 basophil. The serum uric acid was 4.2 mg per 100 ml, and the erythrocyte sedimentation rate was 47 mm per hour. X-ray examinations of the left shoulder, left ankle, and foot were normal. On audiometric examination there was a Bekesy type II response in the left ear interpreted as indicating cochlear pathology, and there was an absence of response in the right ear. Speech discrimination scores were 80% in the left ear, and there was no response in

From the Department of Internal Medicine, Madison General Hospital.

the right. A neurologic evaluation was undertaken, and examination of the spinal fluid, x-ray examinations of the skull, an electroencephalogram and a pneumoencephalogram were normal.

The patient was treated with histamine diphosphate intravenously for seven days, and his dizziness improved slightly during this period. He also was treated briefly with prochlorperazine, hydrochlorothiazide, nicotinic acid, and received a five-day course of heparin sodium and warfarin sodium.

A medical consultant made no additional findings except for some limitation of motion of the left shoulder. He was discharged after 18 days with the diagnosis of vascular occlusion of the right cochlear artery. Four days following discharge from the hospital his left pinna became thick, sore, warm, and red. A diagnosis of perichondritis was made by the otolaryngologist, and oxytetracycline and dexamethasone were given for a four-day course. The left knee then became swollen, and the patient first was seen by the author.

The physical examination demonstrated a chronically ill man, 5′ 9½″ tall, weighing 125 lb, with a blood pressure of 100/60 mm Hg. The left ear was swollen and red. The left knee was one inch greater in diameter than the right and there was fluid in the joint space. There was muscle wasting of the extremities. The rest of the physical examination was not remarkable. The leukocyte count was 20,500 per cu mm and the erythrocyte sedimentation rate was 21 mm per hour. The serum uric acid was 5.24 mg per 100 ml, the latex agglutination was weakly reactive and the VDRL was negative. Fluid obtained from the left knee was sterile on routine culture and culture for tuberculosis and fungi.

Three weeks after the left ear swelled, the right pinna became swollen, red, and hot. The otolaryngologist made a biopsy of the right pinna. This showed "nonspecific inflammatory reaction and degeneration of collagen." The next week the nasal cartilage became inflamed and swollen. The fingers felt tight, but there were no objective findings. No costochondral inflammation was noted. At this point, the diagnosis of relapsing polychondritis was made, and prednisone therapy was started at 30 mg per day in divided doses. Within a month the ear and nose swellings disappeared without deformity. However, the left knee remained swollen, was again aspirated, and was injected with prednisolone suspension. The dose of prednisone was gradually tapered to 5 mg per day. His unsteadiness remained so severe that he was granted total medical disability by a Social Security board.

During the following year he developed pain and swelling in the right knee and ankle which responded to temporary increases of the dose of prednisone. He was fitted for a hearing aid for the left ear. On examination 18 months after the onset, he reported a 20-lb weight gain. His joints were all normal, and no new cartilages showed inflammation or deformity. His erythrocyte sedimentation rate was 18 mm per hour, the latex agglutination was negative, and the serum protein electrophoresis was normal.

The following year he continued to have intermittent inflammation of the ears, knees, nose, and costochondral joints. Two and a half years after onset the patient was seen again. He held on for support when standing or walking. The general examination was unchanged, and the joints were all normal. His leukocyte count was 15,050 per cu mm, the erythrocyte sedimentation rate was 22 mm per hour, the latex agglutination was "doubtful," the LE cell preparation was negative, and the serum protein electrophoresis was normal.

Repeat audiometric examination was identical with the previous testing, and showed complete loss of hearing in the right ear. Caloric examination again showed complete absence of response of the right vestibular apparatus, and normal response on the left. It was felt by the otolaryngologist that the patient had had a vascular occlusion of the right internal auditory artery.

COMMENT

Relapsing polychondritis can be a disabling, crippling, and even fatal illness. A patient has been presented for whom this illness has so far been an annoying accompaniment to another disabling illness, that of occlusion of the internal auditory artery.

Tinnitis and vertigo have been reported as accompanying the polychondritis, but the author feels that the present patient probably has two separate illnesses. His picture and course follow the typical pattern of recurring inflammation of the ears and nasal cartilages, ocular involvement and arthritis with effusion.

The diagnosis was made on clinical grounds and on the biopsy which showed degeneration of collagen. Kaye reported an increase in the urinary acid mucopolysaccharides during exacerbations in some of his patients.[6] This laboratory determination was not made in this case. This entity is of interest to clinicians in many fields of practice, and often has gone unrecognized initially because of its rarity.

Park at Regent (53715).

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Successful Electroconvulsive Therapy in an Adrenalectomized Patient with Endocrine Adenomatosis

By DONALD T. FULLERTON, M.D., FRANCIS N. LOHRENZ, M.D. and WARREN J. HOLTEY, M.D., Marshfield, Wisconsin

■ ELECTROCONVULSIVE THERAPY is a familiar and well-established method of treating depression. Many theories have been advanced to explain its effectiveness. However, none of these theories has been proven and few have been eliminated. One of the suggested mechanisms of action is increased adrenal cortical secretion through stimulation of the pituitary adrenal axis by electrical stimulation of the hypothalamus.[1] However, two cases have been reported of the remission of depression in bilaterally adrenalectomized patients following electroconvulsive therapy.[1] The case we present is another example of the remission of a depression using electroconvulsive therapy in a patient without adrenals.

Because of the general systemic effects, particularly the grand mal seizure, electroconvulsive therapy is a somewhat dangerous procedure particularly in patients with preexisting medical illnesses. The use of barbiturates, muscle relaxants, and artificial ventilation significantly reduces the morbidity rate. The following case is presented to illustrate the effective use of carefully supervised electroconvulsive therapy (ECT) in a poor risk patient with an extremely complicated medical history. The case is also of interest because of recent speculation "that depression may be a central nervous system response to high circulating glucocorticoids."[2]

CASE REPORT

The patient was the oldest of two siblings born and raised in a small central Wisconsin town. His sister was 13 years younger and was a passive, dependent, young woman who lived and worked near her home. The patient's father, the plant manager of a cheese factory for 35 years, was a passive man who was over-shadowed and dominated by his aggressive wife. He provided well for his family, and as the patient recalled, "I had everything I wanted as a kid." The father functioned primarily as a spokesman for the mother and had difficulty expressing his own views or preferences. He was quite intimidated by his wife's aggressiveness and spent much of his time protecting her from any discomfort.

The patient's mother had "only one interest in life and that is my children." She was described by the family as being "highstrung," and tended to be particularly anxious whenever her children made any independent moves. The mother was excessively concerned about the patient's health and felt that whenever he became ill, she had "somehow failed." With the onset of the patient's recent serious medical illness, the mother had become extremely anxious.

As a child, the patient was somewhat shy and inhibited and on the fringe of most social activity. He was an average student throughout grade school and high school but was noted for being remarkably well behaved. He was never involved in any disciplinary difficulties during school and displayed little or none of the usual adolescent rebellion. He attended the University of Wisconsin at Madison where he majored in business. After two years of college, he was drafted and spent two uneventful years in the service. After the completion of his two years of active duty, he returned to the University of Wisconsin where he completed his course work for a bachelor's degree in Business Administration.

After graduation from college, the patient was employed by a large corporation in the credit department. He was told that if he were to be regularly promoted, it would be necessary for him to be moved periodically. However, the patient objected to the idea of leaving the area of his parents' home, so when a transfer and promotion were offered, he quit and went to work for a bank in Milwaukee. Although he performed this job well, he got along very poorly

From the Marshfield Clinic.
Doctor Fullerton is in the Department of Psychiatry; Doctor Lohrenz, the Department of Medicine; and Doctor Holtey, the Department of Anesthesiology.

with his fellow workers. After taking this job, the patient, who had dated very little, became more than ever socially isolated.

While working in Milwaukee, a friend enlisted the patient's help in forming and chartering a new bank. The patient participated actively and contributed significantly to the organization of this bank and was instrumental in issuing the bank's stock. He also solicited the sale of stock and when the bank opened for business, he became the credit manager. He did well on this job but continued to lead an isolated social life with few friends and no dating. He spent the majority of his time working and had little or no recreational outlets. Later the patient recalled that, during this time, he was being "too independent." He didn't want any friends because he didn't "want to rely on anybody" and consequently he isolated himself in order to avoid "personal entanglements."

MEDICAL HISTORY

In February of 1964, the patient fractured several ribs on the right side after a minor fall. In August of 1964, he again had a minor injury which caused fractures of several ribs. Over the next 12 months, the patient developed moon facies and the appearance of Cushing's syndrome. He was examined by an internist in Milwaukee who noted moderate hyperglycemia, diabetes, and physical findings consistent with Cushing's syndrome.

On July 15, 1965, a bilateral adrenalectomy was done at a hospital in Milwaukee. Bilateral adrenal hyperplasia and an adenoma of the pancreas were found. Postoperatively, the patient was started on oral cortisone and had one episode of gastrointestinal bleeding while in the hospital. He was well for one month after discharge, then he noted three or four tarry stools and felt faint. Examination at a hospital in Marshfield revealed a blood pressure of 90/50 mm Hg, residual purplish stria over the lower abdomen, a well healed abdominal scar, a hemoglobin level of 7.4 gm per 100 ml, and a hematocrit reading of 22%.

A diagnosis of massive upper gastrointestinal hemorrhage was made and the patient was given 18 units of blood during the next four days. However, the patient continued to have hematemesis and melena and on Aug. 12, 1965, a 70% gastrectomy and gastrojejunostomy was performed. At the time of surgery, multiple ulcerated areas in the mucosa of the stomach were noted and a pancreatic cyst was found at the site of the previously removed benign pancreatic adenoma.

Postoperatively, the patient required several more transfusions but did well. He developed drainage from a sinus tract in the area of the pancreatic cyst which continued after he was discharged Sept. 13, 1965, on 37.5 mg a day of maintenance cortisone. He was readmitted to the hospital on Oct. 1, 1965, because of enlargement of the sinus tract. His hemoglobin had again fallen to 8.7 gm per 100 ml with a hematocrit reading of 25%.

On October 11, a large pancreatic abscess was drained and it cultured *Escherishia coli*. Drainage tubes were left in place and the cyst area was periodically irrigated. The patient improved gradually during the second hospitalization and was discharged on Nov. 8, 1965. He was readmitted as an emergency case on Nov. 9, 1965, because of bleeding in the area of the pancreatic abscess. On November 10, his abdomen was explored through a lumbar incision; marked bleeding was noted from the pancreatic cyst which had eroded into the splenic artery. An abdominal thoracic splenectomy was done and drainage instituted. Postoperatively the patient gradually resumed maintenance cortisone replacement levels, and was able to tolerate a low residue diet with antacid. He was discharged on Dec. 10, 1965.

During the first admission, it was noted that the patient's blood calcium level was in the hypercalcemic area above 10 mg per 100 ml. Serum calciums continued in the hypercalcemic range during the third admission.

EMOTIONAL RESPONSE TO ILLNESS

During the first few hospitalizations, it was noted by the staff that the patient was extremely dependent upon his parents and that his mother was over-solicitous. She repeatedly verbalized her feeling that the patient was going to die. The patient was quite frightened and concerned about his physical status, but as the trouble went along, he became increasingly depressed. He felt "empty inside" and while lying in the hospital during his third hospitalization, he began to feel "I'll never get back to where I was." He felt that "something has been taken away permanently" that he could not do without and so "I just gave up." He became convinced that he would never get well and when he was told that he would have to have a parathyroidectomy, he felt convinced that "this is the end." He was not able to eat, and related "I'm just not interested in food." He began to have trouble falling asleep, and also woke up too early. He began to have difficulty making decisions and related that he had become hopelessly ambivalent about everything. He became convinced that "there is just no way out of this thing. I used to have some hope but now I realize that there is no way out." The patient felt helpless and hopeless and when it was suggested that he be hospitalized, he replied he thought it would be better if he just stayed home and killed himself. He complained that there wasn't any point in living, and that he was sure that he would never recover enough strength to return to work.

He was hospitalized on the psychiatric service in March 1966 and treated with supportive psychotherapy and antidepressants. His parents were interviewed and attempts were made at family therapy in order to relieve the obviously pathologic familial relationships. However, the patient's situation continued to deteriorate. He became more and more depressed, ate less. It was necessary on several

occasions to tube feed him because of his refusal to eat. He spent most of his time in his room staring blankly at the ceiling and came into the dayroom only when actually forced there by personnel. During this hospitalization, his calcium levels continued in the hypercalcemic range and a parathyroid exploration was performed on Apr. 27, 1966. Two tumor masses were located in the right superior parathyroid regions and both were excised. Microscopic sections showed that both of these excised tumors were parathyroid adenomas. The parents' reaction to the parathyroid surgery had been that of extreme alarm and recurrent predictions by the mother that the patient would "die during surgery." After surgery, the patient's anorexia continued, as well as his feelings of hopelessness and self-depreciation. Finally, it became clear that electric shock therapy was indicated and after much discussion, the patient's father reluctantly consented to this procedure. The patient's mother predicted death for the patient and refused to sign the consent form telling her husband that he would be sorry he had signed after his son was dead.

The electroconvulsive therapy was given with an anesthesiologist (W. H.) in attendance. The patient was premedicated with 0.6 mg of atropine and was fasted for eight hours prior to the procedure. He was given 200 mg of sodium thiopental (Pentothal) and 80 mg of succinylcholine (Anectine) intravenously 70 seconds prior to the electrical stimulus. Artificial ventilation was provided with an anesthetic machine and bag breathing. The patient was given a total of eight electroconvulsive treatments and in spite of his severe generalized osteoporosis, no fractures or other complications occurred. The patient recovered promptly from his depression after the electroconvulsive treatment. His mood improved dramatically, his appetite returned, he began to sleep, and he socialized. He was discharged improved and returned home to live with his parents but has not yet secured employment.

COMMENTS

This case illustrates the development of severe depression in a patient following a serious medical illness and repeated surgical procedures. Although the patient had a history of mild emotional difficulties with an aggressively over-protective mother who attempted to maintain him in a dependent relationship, he did not become clinically depressed until he developed a severe illness which required repeated surgery. Because of this illness, he was forced to be dependent, and the loss of his independence precipitated the depression.

Noteworthy is the observation that this patient did not suffer a clearly defined psychiatric illness while he had Cushing's syndrome. In fact, it seems that at least in regard to his work, he functioned more effectively at the time his adrenals were hyperactive than he did before or since. Also of interest is the fact that depression did not develop clinically in this case until after adrenalectomy. This casts doubt on the suggestion that depression is "a central nervous system response to high circulating glucocorticoids" and supports the hypothesis that depression and hypersecretion of the adrenal cortex are concomitants.[2] This observation of depression following adrenalectomy is corroborated by others.[1]

The role of the endocrine system in the treatment of depression is also clarified by this case. As has been reported previously, intact adrenals are not necessary to achieve a favorable response to electroconvulsive treatment (ECT).[1] This is the third case reported of the remission of a depression with ECT in an adrenalectomized patient and it seems to refute conclusively the theory that electric shock (EST) stimulation of the adrenal-pituitary axis is necessary to bring about remission of depression.

The case also illustrates the safety of ECT in severely ill patients. In spite of serious osteoporosis and a history of multiple pathologic fractures, a course of electroconvulsive treatment was carried out successfully using muscle relaxants and artificial ventilation.

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BOOK: DIABETES FOR DIABETICS

The latest book published for diabetics is *Diabetes for Diabetics* by a practicing diabetologist, George F. Schmitt, M.D. of Miami, Fla. It is available for $5.95 prepaid from Diabetes Press of America, Inc., 30 S.E. 8th St., Miami, Fla. 33131.

Realizing the need for educating the millions of diabetics with basic information about their disorder, the author has written this completely different, practical guide for diabetics. Doctor Schmitt clearly explains the cause and treatment of diabetes, as well as its complications and problems, in simple terms which laymen can understand.

The book is in its third printing. The profits of the Diabetes Press go to camp scholarships for diabetic children. The Dade County Medical Association has given its full support to the book.

Pancreatitis

Current Analysis and Review of 71 Cases

By CLAUDE de FOÏARD–BROWN, M.D., Milwaukee, Wisconsin

STRIKINGLY, in pancreatitis, the most diverging damaging influences, whether studied experimentally or clinically, result in a pathologic picture of unrelieved monotony: chronic fibrosis with destruction first of the exocrine, then of the endocrine components of the pancreas. Histologically connective tissue pervades the gland, separating lobules and single acini until lone nests of cells in diffuse connective tissue remain. Increase in connective tissue is first interlobular, later intralobular. In contrast to this uniform result where any difference is one of degree, the causes of pancreatitis are as variegated as the mantle of Harlequin. In fact, this multiplicity of etiology is a patchwork of causes sometimes overlapping, at other times diverging, none of which suffices to explain fully the origin of pancreatitis.

ETIOLOGY

1. Common Channel Theory. In discussing the etiology of pancreatitis, precedence must be given to the common channel theory, both by reason of its antiquity (Claude Bernard first postulated that bile activated pancreatic enzymes) and because this theory accounts for a substantial portion of pancreatitides. Study of this disease shows common association with cholecystitis or cholelithiasis. It has been proved conclusively that a common channel formed by the confluence of the duct of Wirsung and the common bile duct at their termination is frequent. Opie postulated that a gallstone impacted at the sphincter of Oddi would prevent the outflow of bile and pancreatic juice and would cause reflux of bile into the duct of Wirsung causing pancreatitis. Later studies have shown that this accounts for less than 5% of cases.[1]

It is more likely that obstruction is caused oftener by stenosing papillitis, spasm or edema at the sphincter of Oddi. Foreign bodies such as Ascaris may cause pancreatitis by obstructing the sphincter.[2] These causes might be classified as "retention pancreatitis." How does such a mechanical obstruction produce a pancreatitis? Bile as such does not activate pancreatic enzymes. Reflux occurs readily into the duct of Wirsung in the absence of obstruction with no deleterious effects; the pressure in the duct of Wirsung has been proved higher than that of the common bile duct. Pressures capable of disrupting acini and causing pancreatitis do not occur physiologically. These are some objections advanced against this theory. However, these conditions can be changed.

Pressure studies by Blumenberg and Powers[3] have shown that the pressure relationship between pancreatic and common bile duct can be altered. A duct of Santorini in communication with the duct of Wirsung has been shown to act as a safety vent to allow the pressure in the common bile duct to become a good deal greater than in the pancreatic duct in the presence of sphincter obstruction. Retching raised the pressure in the common bile duct considerably above that in the duct of Wirsung in the presence of a communicating duct of Santorini.[4]

In the laboratory, bile incubated with pancreatic juice or trypsin and introduced into the pancreatic duct caused lethal pancreatitis in experimental animals as did pancreatic juice incubated with blood.

An interesting speculation[5] is that high pressures in both ducts are prevented by the presence of a healthy distensible gallbladder. When it is diseased and no longer distensible, its pressure-regulating ability is lost. This might explain the high incidence of pancreatitis in patients with cholecystic disease. Since those conditions shown experimentally cannot be proved to occur clinically in human patients, the retention theory is open to challenge.

2. Obstructive Pancreatitis. Obstructive pancreatitis includes those pancreatitides caused by obstruction of the duct of Wirsung by tumor, stricture, or pancreatic calculus. Experimentally, such obstructions cause edema only; however, with a superimposed

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vascular element, hemorrhagic pancreatitis ensues.[1,6] Because of abundant collateral circulation, ligation of major vessels will not cause diffuse severe inflammation.

Ischemia severe enough to produce tissue necrosis can be caused only by interrupting the flow in the smaller vessels, with emboli, thrombosis, vasospasm, or vasculitis of any etiology. Within this theme it would be interesting to study the vasculitis of collagen diseases in relation to pancreatitis. Pancreatitis is unlikely to be due to vascular injury alone. If this is superimposed on obstruction to the outflow of pancreatic juices, necrosis of acinar cells ensues and the mechanism of auto-digestion of the pancreas sets in. This is one of the most important causes[1] of pancreatitis.

3. Alcoholic Pancreatitis. Chronic alcohol consumption may cause pancreatitis by stimulating the secretin mechanism. Experimentally in dogs, intraduodenal instillation of alcohol and the inducement of retching raised the pressure in the ducts.[3] Vomiting following heavy drinking could be a precipitating factor. Alcohol, by whatever method, does cause pancreatitis. In alcoholic pancreatitis[1] biliary tract disease is seldom present, and pancreatic calcifications are found more often.

4. Allergic Pancreatitis. The allergic factor which is comparatively neglected will probably be shown to have greater importance than formerly thought. The French and German[7,8] literature describes many cases of pancreatitis associated with allergic manifestations: asthma, drug and food allergies, urticaria, or eosinophilia. The concurrence of pancreatic attacks and cutaneous or other allergic manifestations points strongly in the absence of more common etiologic agents, to a common agent of allergic origin. The mechanism is an antigen–antibody conflict which provokes in the pancreas a discharge of histamine accompanied by the usual histologic disorders, as dilatation, blood engorgement, and edema. This leads to anoxia, tissue necrosis, and extravasation of trypsinogen, which is activated, and by its proteolytic action liberating histidine provokes a discharge of histamine. Thus a vicious circle sets in (Fig 1).

5. Pancreatitis by Contiguity. Collateral inflammation occurs by contiguous and lymphatic spread.[1] In chronic cholecystitis a focus of inflammation is sometimes found in the head of the pancreas, with a chain

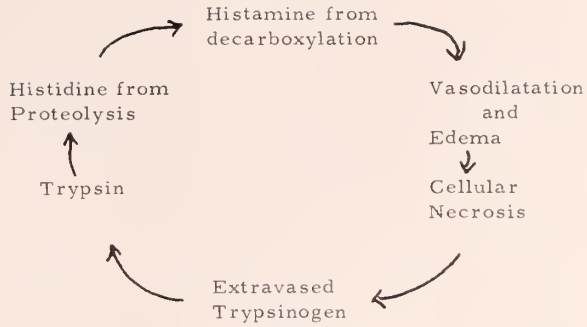

FIGURE 1

of enlarged lymph nodes or edema indicating the path of spread from the gallbladder to the pancreas. Pancreatitis may be associated with penetrating duodenal ulcer or with diverticulitis of the duodenum. This inflammation is circumscribed, never diffuse, and ceases when the cause is removed.

6. Traumatic Pancreatitis. It is caused most often by nonpenetrating abdominal trauma, and sometimes by direct injury (i.e., stabbing or gunshot wounds). Crushing of the parenchyma causes extravasation of its enzymes. The accompanying hemorrhages and possibly a temporary interruption of the pancreatic duct adds to the damage. Closely allied is postoperative pancreatitis. Excessive handling by the surgeon or excessive instrumentation of the common bile duct may lead to extravasation of enzymes or edema of the sphincter, with consequent pancreatitis. Severe postoperative pancreatitis, though infrequent, has a high mortality rate.

7. Miscellaneous Factors. (a) Infective—usually associated with mumps, mononucleosis and epidemic hepatitis. (b) Nutritional with kwashiorkor, sprue, chronic alcoholism. (c) Chemotoxic with methyl alcohol, isoniazid and chlorothiazide.[9] (d) Pancreatitis associated with use of steroids, diabetes. (e) Hereditary pancreatitis.

PATHOGENESIS

Acute and chronic pancreatitis are but stages in the same disease. Its most dramatic and lethal manifestation is acute hemorrhaghic pancreatitis, the "Drame Abdominal" described by Dieulafoy. To trigger it an effusion of pancreatic juice from the secreting canaliculi seems necessary.[10] Activation of trypsin within the pancreas and its eventual dissemination into the circulation represents the central factor. From this a series of reactions occurs.

(1) Trypsin activates proteolytic ferments (chymotrypsin and carboxipeptidases) and in alliance with them attacks the glandular and connective elements of the pancreas leading to edema, necrosis and hemorrhage. It destroys endocrine as well as exocrine tissues, leading to disorders of glucose regulation and liberates lipases.

(2) Trypsin is the source of important vasomotor disturbances, producing shock, hypotension, and collapse: [a] Activation of kallikrein, a pancreatic vasodilator and hypotensive agent. [b] Liberation during proteolysis of histamine bradykinine and kallidine which reinforce the action of kallikrein.

(3) Trypsin and other enzymes in the circulating blood provoke an enzymatic toxemia with an encephalopathy resembling a confusional state or dilirium tremens. As soon as trypsin is triggered it acts as a "reactor of enzymes" in the pancreas which becomes the theatre of a chain of reactions leading to the gravest disorders. Under these circumstances one can understand the capital interest of substances which can inhibit those nefarious enzymatic reactions and inactivate in some way this process.

DIAGNOSIS

A. Clinical Diagnosis. (1) In chronic pancreatitis there is severe upper abdominal pain, gradually progressing until it becomes intractable. In acute pancreatitis, the "Drame Abdominal" shows the picture of an acute, quickly progressing peritonitis with brutal upper abdominal pain. The possibility of pancreatitis should always be borne in mind in any patient with upper abdominal pain. (2) Anorexia, nausea, vomiting, loss of weight. (3) Icterus (50% of cases in Hess's series[1]). (4) Endocrine disturbances (i.e., diabetes). (5) Paralytic ileus. (6) Kidney damage, hypocalcemia, shock, collapse are rare though classical. (7) Fluid and electrolyte loss (which may be considerable).

These signs and symptoms being nonspecific must be supplemented by the other elements of diagnosis:

B. X-Ray.[1,11] X-ray examination may demonstrate (a) biliary or pancreatic lithiasis, (b) a sentinel loop, (c) duodenal loop deformities, even a left pleural effusion or atelectasis, which induces suspicion of the diagnosis.

C. Laboratory Tests. The most valuable diagnostic aid is serum amylase evaluation

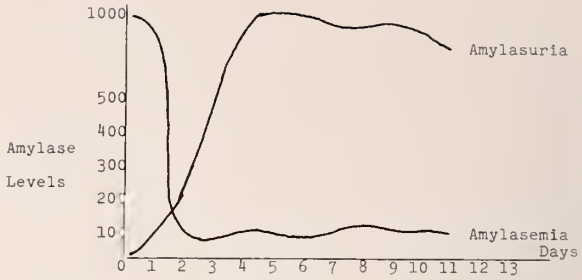

FIGURE 2

in the first 24 to 48 hours, later urinary amylase which remains elevated much longer.[12] If plotted the two curves cross each other on the second to fourth day of the illness (Fig 2).

These are the most valuable tests available though they will not indicate the degree of pancreatitis accurately, since the amylases do not participate in the damages caused by pancreatic enzymes. There are also other causes of hyperamylasemia: mumps, intestinal occlusion, perforated peptic ulcer, rupture of ectopic pregnancy. However, hyperamylasemia is an important witness in 87% of acute pancreatitides, as shown in our series (Table 1).

Serum lipase is also valuable though not as reliable. Abdominal or pleural tap may yield sanguinolent fluid rich in amylase. Serum calcium may be decreased or blood sugar increased. The secretin-pancreozymin test of Dreiling, which gives good results in diagnosing chronic pancreatitis, is somewhat time-consuming to perform.

D. Scanning with Se 75 (seleno-methionine)[13] is based upon the ability of the pancreatic acinar cells to capture the circulating molecules of methionine which then aid in constructing the zymogen molecules.

TREATMENT OF PANCREATITIS

Knowledge of the physiology of the gland and whatever insight we have of the pathogenesis of pancreatitis determines conservative treatment, which is:

A. Conservative

(1) Nothing by mouth; continuous nasogastric suction to control the ileus and prevent the stomach contents from stimulating pancreatic secretion through the secretin mechanism.

(2) Parenteral atropine (0.5 mg every three to four hours), methantheline bromide (Banthine), or propantheline bromide (Pro-Banthine) reduce sphincter spasm and also

TABLE 1—*Review of 71 cases of proved pancreatitis (1963–1966), including 33 males (age 23 to 78) and 38 females (average age 50)*

	No. Patients	Percent
Etiology		
Gallbladder or biliary tract disease	30	42
Alcohol	15	21
Postoperative	4	6
Not obvious	22	31
TOTAL	71	100
Diagnosis		
Upper abdominal pain	66	
Tests		
Elevated serum amylase	46	65
Elevated urinary amylase	16	22
Elevated serum lipase	4	5
Diagnosed at autopsy	1	
Diagnosed on exploration	1	
X-Rays		
Gallstones and common duct stones	10	
Pancreatic calcifications	1	
Ileus	12	
Dilated pancreatic duct	1	
Duodenal signs (widening of loop, evidence of extrinsic pressure, etc.)	7	

the vagal mechanism of pancreatic secretion.

(3) Replacement of the sometimes massive loss of blood, fluids, and electrolytes. Low levels of calcium and phosphates indicate poor prognosis.

(4) Analgesia is very important. Morphine must be excluded since it causes spasm of Oddi's sphincter. Meperidine hydrochloride (Demerol) is more acceptable. Chlorpromazine may help to potentiate this drug and is also a sedative. For retractable pain an intravenous infusion of procaine[1] (1.0 Gm in 500 ml of normal saline), splanchnic or epidural block may be helpful.

(5) Steroids may be of value in profound shock.

(6) Enzyme inhibition, the use of Trasylol in large doses is a new and very hopeful method of treatment.

(7) Prophylactic use of antibiotics to prevent superimposed infection.

(8) Antihistamines may help in allergic pancreatitis.

(9) Miscellaneous drugs: [a] Acetazolamide (Diamox) to reduce activation of procarboxypeptidases and carboanhydrase. [b] The use of propylthiouracil to reduce cellular metabolism.[14] [c] Quinine has neutralized pancreatic lipase in vitro.

(10) Hypothermia may be used to retard the progressive pathologic change.

NEW TECHNIQUES

1. The technique of direct organ perfusion opens up horizons of future hope. It consists of the injection of large doses of Trasylol (250,000 units) directly into the pancreas by way of the celiac artery. A Saldinger needle is used to puncture the femoral artery, an Odman catheter passed into the abdominal aorta and manipulated into the celiac artery. Good results are reported.

2. Direct instillation of large doses of Trasylol into the abdominal cavity has been attempted in Australia with apparently good results.

Trasylol. Over 300 European papers have testified to the success of treatment of pancreatitis with Trasylol, a kallikrein–trypsin inhibitor produced from the parotid of the ox. It is a polyvalent inhibitor acting on trypsin, chymotrypsin, kallikrein, and prevents the activation of trypsinogen. It does not destroy but merely inhibits them and renders pancreatic secretions inoffensive. It must be remembered that this valuable drug is a symptomatic rather than etiologic treatment. It is able to oppose the extension of the tryptic process, but the necrotic lesions still present remain unchanged. If that drug is given early enough and in large enough doses, the extent of destruction should be greatly curtailed. Trasylol is remarkably free from side effects, and very large doses may be used with impunity (up to 200,000 to 300,000 K.I.U. daily). American opinion seems to be less enthusiastic than the European. A recent double blind study by Nardi[14] on 22 patients did not find a significant difference between patients who did or did not receive Trasylol.

B. Surgery

The physician will have recourse to surgery only after the acute attack has been controlled and to remove the cause and prevent recurrences. Thus surgery will not be an emergency procedure. If pancreatitis is found in an exploratory laparotomy, ordinarily the abdomen should be closed and conservative management instituted. However, successful management has been re-

TABLE 2—*Treatment*

Treatment	No. Patients
Medical	
Recovered	68
Died	3
Had recurrences	20
Surgical	
Cholecystectomies and choledochotomies	9
Exploratory laparotomy	1
Drainage of pseudocyst	1
Recovery or improvement	10
Deaths	1

ported with removal of a diseased gallbladder or by exploration of the common duct to remove stones, or by immediate drainage of abscesses or pseudocysts. In general, surgery means delayed operations following a symptom-free period, with cholecystectomy, choledochotomy, sphincterotomy, or retrograde drainage procedures.

REVIEW OF CASES

Evaluation of 71 patients with clinically proved pancreatitis (Table 1) shows 30 (42%) to be associated with gallbladder or biliary tract disease. In 15 (21%) there was an associated history of alcoholism, but in 22 (31%) the etiology was not obvious. Diagnosis was based almost entirely upon elevation of serum or urinary amylases (87%).

All of these patients in whom this diagnosis was made were treated conservatively (Table 2). Three patients (4%) died of overwhelming disease; the others all recovered with, however, a recurrence rate of 20%. Only 2 patients received Trasylol, without any apparent benefit. Surgical treatment was given to 11 patients. Of these, one was found to have a pseudocyst, and died shortly after operation. Another patient had an exploratory laparotomy during which pancreatitis was found. This patient, as well as the others who had cholecystectomies and common bile duct explorations, recovered and have remained well since (Table 2).

In these patients a constant search for the etiologic factor should be made in an attempt to control the disease before the damage becomes irreparable. On the basis of this study, it is felt that in all patients with acute upper abdominal pain of questionable etiology, serum or urinary amylases or both should be evaluated. If there is the slightest suspicion of pancreatitis, the patient should be put on conservative management while further investigations proceed.

CONCLUSION

An extensive study of the American and European literature demonstrates a multiplicity of causes of pancreatitis. In spite of much clinical and experimental work, diagnosis is often difficult and may depend upon one or two laboratory aids, mainly amylase determinations. Provided suggestive symptoms and signs are present, this diagnosis should be kept in mind, and treatment instituted even before the examination of the patient is completed.

In any patient with acute upper abdominal pain, suspicion of the presence of pancreatitis should be entertained. Treatment is to be conservative at first with rare immediate recourse to surgery, although subsequent definitive surgery often must be done. A review of 71 cases from the author's hospital clarifies those assertions. A review of new therapeutic techniques, particularly with regard to the use and mode of action of Trasylol, is included.

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Reportable Adverse Drug Reactions

By RICHARD I. H. WANG, Ph.D., M.D.
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COMMENTS ON TREATMENT

Presented through the cooperation of the Department of Pharmacology, Marquette University, Milwaukee, and the Department of Medicine, University of Wisconsin, Madison

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■ THE AMERICAN MEDICAL ASSOCIATION and the Food and Drug Administration have been interested in receiving reports from physicians throughout the country on cases of adverse drug reactions. Comprehensive review of collected data, however, has been rather scarce. Two surveys, both published in 1964, one from the Grace–New Haven Community Hospital and the other from the Johns Hopkins Hospital, showed that reaction to therapeutic agents is one of the common reasons for admission to a medical service.

In a four-month period 15% of the patients at Johns Hopkins Hospital had drug reactions. The most significant point of this survey is that 8 of the 36 patients admitted with drug reactions died during the course of this hospitalization. They included all adverse drug reactions whether the etiologies were attempted suicide, accident, or homicide. These data, however, may or may not be representative of the patient population of other hospitals throughout the country.

From a practical point of view, the frequency of occurrence of any particular drug reaction cannot be estimated with any degree of reliability and accuracy. One possible discrepancy might be due to the variability in recognizing and interpreting drug reactions. With the hope of providing better recognition and reporting of adverse drug reactions, this paper is written to review some of the basic phenomena and to clarify the status of reportable adverse drug reactions.

Every drug has desirable (therapeutic) and undesirable (toxic) effects. The frequency of occurrence of these effects with increasing doses of a drug follows a Gaussian or normal distribution. Reactions can occur at any given dose level. There are two types of drug reactions. One is toxic; the other is allergic. Toxic drug reaction is dependent on the dose level. It usually occurs as a result of an overdosage so that the principal action and side effects of the drug are exaggerated. Occasionally, it occurs with less than the usual dose. This is due to the patient's natural ability to absorb, to inactivate, or to respond to the drug. In toxic reaction, therefore, the signs and symptoms manifested by the patient can often be explained by the pharmacologic properties of the drug. Compounds with similar *pharmacologic activity* will produce cross toxic reactions and the reaction time for the occurrence of the toxic reaction is quite reproducible. Treatment of toxic reactions involves the use of antidotal and supportive therapy.

Allergic drug reaction is independent of dose. Generally, its symptomatology is not related to the pharmacologic properties of the drug. Compounds with similar *molecular structure* will produce cross allergic reactions. The reaction time for the occurrence of allergic reaction is shortened when the patient is rechallenged with the drug. Treatment of such reactions is the use of antiallergic therapy.

Based upon the rate of development, allergic reactions are characterized by the following three types:

(1) *Immediate reaction* is signified by the appearance of numbness, tingling, syncope, anaphylactic shock, or death.

(2) *Intermediate reaction* is signified by the development of asthma, urticaria, skin rash, or angioneurotic edema.

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(3) *Delayed reaction* is signified by the development of serum sickness, dermatitis, purpura, fever, leukopenia, anemia (hemolytic or aplastic), polyarthritis, disseminated lupus erythematosus, jaundice, or photosensitivity.

Numerous expressions such as adverse, untoward, undesirable, unexpected, and so forth are being used to designate drug reactions. Sometimes adverse drug reactions are also known under the category of "diseases of medical progress." The Food and Drug Administration defined an adverse drug reaction as "one which is noxious, unintended and occurs at doses normally used in man for the prophylaxis, diagnosis, or therapy of disease, or for the modification of physiological function."

The precise frequency of adverse drug reactions is unknown. Obviously, the incidence is much higher than that of the clinically recognized cases. The responsibility of the physician to recognize, interpret, and diagnose drug-induced disorders is even greater than that required in the diagnosis and treatment of patients' ailments.

The ability to recognize drug reactions is really dependent upon and directly proportional to the physician's knowledge of clinical pharmacology. The chances of overlooking drug reactions are greatly increased if the physician is not aware of the possible reactions to a particular drug. On the other hand, if an adverse drug reaction is recognized, it should be interpreted, correlated and then contributed to a pool of information from which the incidence of adverse reaction to a particular therapeutic agent can be inferred.

It should be pointed out that the incidence of adverse drug reaction is not synonymous with reportable drug reactions. If every adverse drug reaction were to be reported, the medical literature would be flooded with duplications. Thus, one dilemma facing the medical profession is the selection of drug reactions to be reported. The decision becomes even more difficult for those who have a fair grasp of clinical pharmacology. A drug reaction considered to be quite bizarre in the experience of one physician might not alarm another physician. For this reason, criteria for reporting adverse drug reactions must be established, if meaningful information is to be collected to benefit both the patients and the physicians.

Our interpretation of the types of adverse drug reactions that are reportable can be divided into the following categories:

(1) *Unknown or little known reactions.* For example: retroperitoneal fibrosis induced by methysergide; fulminating liver disease following barium enemas containing tannic acid; deposition of pigment in the fundus and/or the development of lenticular opacities in patients receiving chlorpromazine.

(2) *Unusual, though known, reactions.* For example: Aplastic anemia induced by chloramphenicol; jaundice or agranulocytosis caused by chlorpromazine; diabetes mellitus occurring during thiazide therapy; anaphylactic reaction to penicillin; vestibular and auditory damage secondary to streptomycin and dihydrostreptomycin; anaphylactic reactions to BSP; acute hypertensive crisis in patients with tranylcypromine.

(3) *Questionable reactions* which may be due to the drug although a cause–effect relationship cannot be definitely established. For example: hepatotoxicity following halothane anesthesia; thromboembolic phenomena occurring in women using oral contraceptive agents; symptoms coincident with, but probably unrelated to, drug administration.

In summary, reportable adverse drug reactions represent only a small part of the overall incidence of reactions. Obvious pathologic changes caused by drugs such as anaphylactic shock, urticaria, rash, respiratory depression, jaundice, and the like are readily detectable. However, therapeutic agents can induce symptomatology such as drug fever, urinary retention, pigmentation of fundi, retroperitoneal fibrosis, and the like which can be easily overlooked. With proper knowledge of clinical pharmacology, physicians can contribute confidently toward the establishment of a sound and useful adverse drug reaction reporting program.

* * *

THE VALUE OF unsaturated fats in the diet to prevent or moderate hardening of the arteries is being determined in a study of 400 domiciliary members at the Los Angeles Veterans Administration Center.

CHEMOPROPHYLAXIS OF TUBERCULOSIS

By JOSEF PREIZLER, M.D.
Madison, Wisconsin

THE NUMBER OF newly reported active tuberculosis cases is declining in Wisconsin. It is estimated that over 75% of the new active clinical cases occur among persons previously infected. Prophylactic treatment, or very early treatment, has been found to be remarkably effective in preventing tuberculosis among persons in a high risk group. In large-scale trials conducted by the Public Health Service, isoniazid taken daily for one year prevented most of the serious extrapulmonary complications of primary tuberculosis in young children and reduced markedly the incidence of tuberculosis among household contacts of newly diagnosed active cases. The number of active cases among mental hospital patients was markedly reduced during the year the drug was taken.

Isoniazid hydrazate (INH) in 300 mg daily dose for adults (persons older than 15 years) and 5 mg/kg body weight (approximately 100 mg for each 50 lb of body weight) for children given for 12 months reduced the development of clinical tuberculosis fifteen-fold as compared to the control group in large-scale clinical trials. The effectiveness of the twelve months' medication carried over to subsequent years and resulted in a much smaller number of clinical cases of tuberculosis in the medicated group than in the placebo group.

An interagency committee of the Wisconsin State Board of Health and the Wisconsin Anti-Tuberculosis Association prepared a list of recommendations for chemoprophylaxis of tuberculosis to be used by public health agencies. A copy of the recommendations of this group is printed below. The recommendations are basically in agreement with the recommendations of the American Thoracic Society and were approved by the Division on Chest Diseases of the State Medical Society of Wisconsin.

Isoniazid is relatively inexpensive, rarely causes side effects, is easy to take, and is accepted by most patients. Physicians will find families who cannot afford to pay for medication or who would be more cooperative if the drugs were available to them. The State Board of Health makes available isoniazid free of charge for this type of patient. Our Department will mail a three months' supply of drugs to the patient. We will send a second three months' supply without renewal of the prescription with a note that the patient needs a new prescription for the second six months' supply. Registration forms are available from our Section.

Chemoprophylaxis is a new concept of tuberculosis control. Wisconsin has a low rank (41) in the order of tuberculosis prevalence among the 50 states of our country. With the help of the practicing physicians of our state, we look forward to having only the irreducible minimum of new tuberculosis cases in Wisconsin.

* * *

III. INDICATIONS FOR CHEMOPROPHYLAXIS

A. General Indications:

1. *Any known cases treated without adequate drugs* should be restudied for consideration of chemotherapy. (Patients who have had clinical tuberculosis and cured without use of drugs experience the highest rate of reactivation of their disease, among all persons infected with M. tuberculosis organisms.)
2. *Tuberculin reactors with an abnormal chest x-ray film* have a high priority for chemoprophylaxis. (Studies show that positive reactors who have demonstrable changes in the lung fields of their chest x-ray films show a high rate of breakdown with clinical tuberculosis.)

NOTE: All tuberculin-positive children through age three should be considered as having active disease, even if their chest X-ray film is normal. They are not subjects for chemoprophylaxis.

B. Indications for Chemoprophylaxis for Children:

The priorities for preventive treatment of children with tuberculin-positive reactions and without demonstrable pulmonary lesions are:

1. *Ages four to puberty*—the need for chemoprophylaxis should be evaluated by the attending physician. Consider factors such as the size of the tuberculin reaction, recent known exposure, prolonged contact, massive exposure, general condition of health, weight, intercurrent illnesses such as measles and whooping cough, socio-economic status, and the like.
2. *Puberty* is a period of increased danger and high priority for chemoprophylaxis.
3. *Converters within one year irrespective of age*—particularly if known to have been exposed to an infectious case or if the tuberculin reaction is large. Under some circumstances if the exposure has been heavy, give chemoprophylaxis even if the reaction is negative.

Doctor Preizler is Deputy Director, Section on Preventable Diseases, Wisconsin State Board of Health.

Primary tuberculosis infection is particularly dangerous in infancy and is also dangerous in adolescents (as well as young adults).

Tuberculin-positive children should be studied for extra-pulmonary infections.

C. Indication for Chemoprophylaxis for Adults:

Priorities for preventive treatment of adults with reactions of 10 mm or more and without demonstrable pulmonary lesions are highest in the presence of the following:

1. Conversion to positive within one year—particularly if known to have been exposed to an infectious case or if the tuberculin reaction is large.
2. Adverse socio-economic conditions.
3. Silicosis.
4. Corticosteroid treatment.
5. Diabetes.
6. Postgastrectomy.

HAND INJURIES IN CHILDREN

SIDNEY K. WYNN, M.D. and WILBERT WIVIOTT, M.D., Marquette University School of Medicine, Milwaukee Children's, Mt. Sinai, and Milwaukee County Hospitals, Milwaukee: *Inter. Surg.* 46:283–288 (Sept) 1966.

Hand injuries in children are treated with the same basic careful type of surgical technique as one would use on any hand injury. However, the one advantage regarding the injured child's hand during treatment requiring prolonged immobilization is that the hand does not become stiff. Thus, much can be done, with initial surgery and with secondary reparative surgery in the young that can not be done in the adult.

In patients up to the age of puberty flexor tendon repair in the so-called "no man's land" have been repaired with satisfactory results at the time of initial treatment.

With loss of skin and exposure of tendons and joints, a skin graft frequently will survive and become both functionally and cosmetically acceptable where the same injury in an adult would have required a pedicle flap for survival of the underlying tissue.

In hand injuries of children it is important to do as complete an examination as possible during the initial examination preliminary to operation and by direct examination during surgery. It is important to do careful corrective surgery, preserve and do primary repairs of all identifiable tissues.

CHEMOTHERAPY OF DISSEMINATED SOLID TUMORS

FRED J. ANSFIELD, M.D.: Charles C. Thomas, Springfield, Ill. 122 pages. $7.50.

Before 1960, less than 10% of patients with disseminated cancer received chemotherapy, as compared with well over 50% today. By the end of the decade, predicts the author of this monograph, nearly all patients in this category will receive a trial with chemotherapy.

The book is based on experience gained in treating over 3,000 patients at the University Hospitals in Madison, Wis. The author, a professor of Surgery in the clinical oncology division, points out that "we recommend chemotherapy early and do not wait until the patient becomes symptomatic." After explaining the reasons for this aggressive approach, Dr. Fred J. Ansfield discusses drug evaluation, the management of drug toxicity, and the specific treatment employed by the Madison group.

Wisconsin's Medical School:

A Living Chronicle of the First Century

On Wisconsin Alumni Day, May 26, the official publication of the book, "The University of Wisconsin Medical School: A Chronicle, 1848–1948," by Dr. Paul F. Clark, will be announced. Doctor Clark, emeritus professor of Medical microbiology, spent three years in the writing of this historical document at the request of the Wisconsin Medical Alumni Association.

The first review of the chronicle was written by Dr. Nikolaus Mani, head of the Medical School's history of medicine department. Doctor Mani writes that Doctor Clark "is an accomplished historian and belongs to the pioneers of the Medical School to which he devoted his life work. He is a sensitive and keen observer of men and he writes well. Thus his history is more than a dry catalogue of facts, institutions and persons. . . . His history is living history; it has the flavor of the past and the acting persons are of flesh and blood . . . his history breathes life."

Prepublication orders are being accepted at $8.50 per copy. Post publication price will be $10.00. Orders may be sent to: Wisconsin Medical Alumni Association, 333 N. Randall Avenue, Madison, Wis. 53706.

THE NEW PRESIDENT

HAROLD J. KIEF, M.D.

A Fond du Lac general practitioner, who gives special attention to public health, became the 112th president of the State Medical Society at its Annual Meeting in Milwaukee May 9–11. Dr. Harold J. Kief, who has held several posts in county and state medical society activities, will serve a one-year term in office.

Doctor Kief was born in Milwaukee Nov. 24, 1912. A 1937 graduate of Marquette University School of Medicine, he first practiced at St. Cloud, Wis. After war service, 1942–1946, he began practicing in Fond du Lac. Doctor Kief has been the city's public health officer for 18 years.

Doctor Kief's medical society association began in 1939 when he joined the Fond du Lac County Medical Society. At the county level, he is a past president of the county society and has served as chairman of the utilization committee, chairman of the speakers bureau, and chairman of the public relations committee.

In State Medical Society affairs, Doctor Kief served as a delegate from the Sixth Councilor District and was a member of the Council eight years before resigning to become president-elect. He has been vice-speaker of the House of Delegates, member of the Council on Medical Service, and an advisor to the State Medical Assistants Society. As a Councilor, Doctor Kief was a member of the Executive Committee and chairman of the Planning Committee.

Active in community affairs, Doctor Kief was chairman of Fond du Lac's Red Cross accident prevention program, organized and served as first president of the city's Toastmasters Club, and for many years served as medical examiner for the area's Federal Aviation Control (FAC). In 1963 he received a citation of President Johnson for 17 years of service as medical advisor to the local Selective Service Board. He has been active in the Lions Club, Association of Commerce committee on legislation, Boy Scouts, Easter Seal Committee, Camp Waubeek, and the Guidance Clinic. He is a past president of the Lions Club.

Doctor Kief is associated with Drs. N. O. Becker, W. E. Myers, J. U. Peters, and R. N. Benneyan who form a group, Associated Physicians of Fond du Lac, formerly the Gavin Clinic. He is currently affiliated with St. Agnes Hospital, and has been chairman of its executive committee. He holds memberships in the American Academy of General Practice and the American Public Health Association as well as his county and state medical societies and the American Medical Association.

Married to the former Mary Lewis of Milwaukee, the couple's children are John, a captain in the U. S. Army Medical Corps, stationed at El Paso, Tex.; Daniel of Sun Prairie; Michael, student at Wisconsin State University–Oshkosh; Kathy, Mary, and Joanne, at home.

STATE MEDICAL SOCIETY OF WISCONSIN
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EDITORIALS

D. N. GOLDSTEIN, M. D., *Editorial Director*

The Doctor and the Drop-out

■ ALTHOUGH THE YOUNGSTER who drops out of school presents a social and economic problem, the family physician may, in some cases, identify and alter circumstances that produce the problem. Through his familiarity with the family and with the members of the family as individuals, the doctor can often reach the potential school drop-out as a human being rather than as a statistic to discover the factors which have produced this erratic behavior.

It is ironic that our nation is now confronted with this particular educational problem just as it has achieved one of its most cherished goals. Universal education and a complex of high quality educational facilities represented one of the ideals not only of the American pioneers, but of the millions of immigrants who came to these shores. To them the opportunity for academic advancement implied the opportunity for economic and social advancement. To know more was to do more, and to do more meant affluence, upward social mobility and higher self-esteem.

Disappointingly, the beneficiaries of the vast educational system that has been established are also the victims of other factors which have nothing to do with schools. These are economic, social, demographic and emotional in nature. They derive from all the unresolved human problems of our complicated, infinitely variegated western culture.

Traditionally, the school drop-out was the young person who had to go to work in order to help support the family. More recently, in the era of almost full employment, the drop-out was lured by the opportunity to earn what seemed to him "big money." Typically, however, the present day drop-out does not earn as much as the youngster who completes his education and substantially less than the person who goes on to college. Investigation of the problem suggests that the reasons for dropping out of school are largely emotional rather than economic. The abrupt discontinuance of academic education seems to be one means of expressing discontent, anger, hostility, despair, rebellion and other emotional storms. It is here that the family doctor, through his professional relationship with the family, can tag emotional developments that could lead to dropping out of school—and worse.

It has been pointed out that a youth is not actually a drop-out until he is strong enough physically, independent enough emotionally, and old enough chronologically to stand free of parental and social disapproval as well as legal opposition. But the actual dropping out is prefigured by psychological developments that may go back to pre-school years. The parent-child relationship appears to be largely determining future behavior, and the family physician can often warn the parents of the consequences of oversubmission to the child, overcoercion or other neurotogenic manifestations. For the physician has a rare opportunity to individualize the problem before it becomes irreversible . . . before the psychological problem becomes a social and economic dilemma.

By being alert to emotional indications in his patients, by astute counselling, and by sympathetic demeanor, the family doctor can make an important contribution not only to the social and economic well-being of his patients, but also to reduction of a serious problem of our society. It isn't enough to participate in community-supported clinics concerned with drop-outs; the position and competence of the doctor should be brought to bear on the potential drop-out as soon as the first signs of trouble show themselves in any young patient.—D.N.G.

GUEST EDITORIAL

Causes and Consequences

EVERY CAUSE has a consequence, and every consequence becomes a new cause. One sees validating evidence on every hand if he cares and dares to look.

Great strides have been made in the practice of medicine since the first surgery under anesthesia was performed in 1842. Even greater strides are promised—a cure for everything but the common cold!

Most of this progress is the consequence of research and experience. But it is also the cause of new problems, many of which are moral problems which scientific acumen alone is inadequate to resolve. Physicians, and all other science-oriented persons, cannot shrug their shoulders in the face of these problems they have helped create and advance the argument that these are problems for the moralist and the philosopher. They are human problems, facing each individual, and physicians cannot separate themselves from the rest of the human race.

This is an area, therefore, where physicians and clergymen can and must cooperate for the good of all. The life-span has been prolonged and will no doubt be further prolonged. But to what end? To live long without living well is scarcely worth the effort. What can we offer of meaning and significance to a human being who has survived into his ninth or tenth decade?

Is it not likewise true that modern medicine has, in a sense, reversed the process of evolution? The survival of the fittest is no longer a law of life. The unfit, in the sense of those who inherit and pass on diseases such as hemophilia, for example, are proliferating. The aged, the chronically ill, the mentally retarded are all increasing in numbers and presenting man with new problems. Each cause has a consequence, and every consequence is another cause.

The solutions are not simple nor easy to come by. They are not to be found in science alone, nor in moral philosophy alone, but in a combination of both. The physician cannot be expected to "play God" by making decisions which are not of a purely medical nature. The clergyman cannot make these decisions either, but together they can assist the patient and/or his family in making such decisions.

Physicians and clergymen are today cooperating in many new and productive ways. But the area of that cooperation must yet be enlarged. My own experience in the pastorate has, in this connection, been good. There are some doctors who have been of great help to me in my efforts to aid and understand a particular patient and his problem. Occasionally a doctor has consulted me about his patient and my parishioner. I have had many worthwhile conversations with men in the medical profession which have given me new information and insight. The patient and parishioner always benefit.

In such ways we can learn how best to treat the patient as a whole person with not only physical needs, but spiritual, emotional and social needs as well.—REV. NORMAN S. REAM, *Minister*, First Congregational Church, Wauwatosa

SPECIAL TO THE JOURNAL

ANO-BOWEL CANCER

A Survey of Digital and Endoscopic Practices

By A. L. VAN DUSER, M.D., M.P.H.
and C. W. LEMKE, M.P.H.
Madison, Wisconsin

THE REDUCTION of deaths due to ano-bowel cancer is a major objective of the American Cancer Society. To help guide its efforts, the Wisconsin Division of the American Cancer Society requested the cooperation of the State Board of Health in a survey to elicit information on:

(1) The frequency of nonradiologic ano-bowel examinations of adult patients by physicians and hospitals.

(2) The attitude of physicians and hospitals toward educational activities to stimulate and extend practices for finding early ano-bowel cancer.

Two questionnaires were designed for these purposes, one intended for physicians in private practice and the other for hospitals. The former was distributed through the facilities of the State Medical Society, and the latter by the American Cancer Society. Questionnaires were sent only to physicians and hospitals located in the area covered by the Wisconsin Division of the American Cancer Society: this includes all of the state except Milwaukee County. Both societies used only one mailing and no follow-up of nonrespondents was made. All returns were analyzed by the Wisconsin State Board of Health.

PHYSICIAN'S QUESTIONNAIRE

Response

A total of 2,568 questionnaires were distributed to members of the State Medical Society, of which 1,335 were returned. The respondents to the questionnaires were divided into two groups: those whose primary specialty was not related to the subject or who were not in practice; and, those who reported a specialty related to the survey subject. Specialties considered to be related were: colon and rectal surgery, gastroenterology, general practice, general surgery, general preventive medicine, internal medicine, obstetrics and gynecology, and urology.

Table 1 shows an estimated total of 1,602 physicians engaged in related specialties, of which 63.3%, or 1,014, returned questionnaires. Thus the 1,014 returns represent the practice and opinion of the medical segment, exclusive of Milwaukee County, most concerned with the subject matter and should not be construed as being a random sample of the profession as a whole.

Findings

Table 2 shows the variation in frequency of use of three types of examinations as part of general adult physical examinations. A total of 766, or 75%, of responding physicians replied that they perform digital rectal examinations routinely. However, only 9% of the respondents perform the proctosigmoidoscopic examination routinely, 50% do it frequently, and 35% do it seldom or never. The stated frequency of doing anoscopic examinations is almost identical with the frequency of proctosigmoidoscopic examinations, suggesting that respondents may not have differentiated between anoscopics only and anoscopics as part of proctosigmoidoscopy.

Table 3, in comparison with Table 2, shows a striking increase in the proportion of respondents using each technique routinely in patients with symptoms of possible ano-bowel disease. Nevertheless, in this patient category only 66% of the respondents perform proctosigmoidoscopy routinely, 16% do it frequently, and 15% seldom or never do it. No information was obtained on the proportion of physicians who referred patients for the performance of these examinations.

The questionnaire further shows that 581, or 57% of the respondents, perform ano-bowel biopsies routinely or frequently when indicated, and that 36% seldom or never perform biopsies. Most of this latter group reported that patients were routinely or frequently referred for biopsies.

In the group of 581 physicians performing biopsies, 10% usually did them in their offices, 46% usually did them in hospitals, and 41% commonly used both facilities.

The final query on the physician's survey related to educational programs intended to increase the possibility of the early detection of ano-bowel cancer. A total of 320 (32%) of the respondents fa-

TABLE 1—*Response by broad specialty groups*

Specialty	Estimated Distribution of Physicians Queried*	Number Responding	Per Cent Responding
Unrelated	966	321	33.2
Related	1,602	1,014	63.3
Total	2,568	1,335	51.9

*Tabulations from the American Medical Directory, 1965, show 62.4% of Wisconsin's physicians to be engaged in practices related to the subject of the questionnaire; the 2,568 physicians queried are assumed to have the same distribution.

Doctor Van Duser is Director of the Division of Cancer Control, and Mr. Lemke is Director of the Division of Research, Wisconsin State Board of Health.

TABLE 2—*Physicians performing ano-bowel examinations as part of general adult physicals, by kind and frequency of examination*

Examination Is Performed	Type of Examination					
	Digital Rectal		Anoscopic		Proctosigmoidoscopic	
	Number of Physicians	Per Cent	Number of Physicians	Per Cent	Number of Physicians	Per Cent
Routinely	766	75	132	13	89	9
Frequently	220	22	532	52	510	50
Seldom or Never	20	2	302	30	355	35
No Answer	8	1	48	5	60	6
Total	1,014	100	1,014	100	1,014	100

TABLE 3—*Physicians performing ano-bowel examinations for patients with symptoms of possible ano-bowel disease, by kind and frequency of examination*

Examination Is Performed	Type of Examination					
	Digital Rectal		Anoscopic		Proctosigmoidoscopic	
	Number of Physicians	Per Cent	Number of Physicians	Per Cent	Number of Physicians	Per Cent
Routinely	961	95	617	61	666	66
Frequently	36	3	151	15	167	16
Seldom or Never	7	1	164	16	156	15
No Answer	10	1	82	8	25	3
Total	1,014	100	1,014	100	1,014	100

The Attack on Cancer of the Colon and Rectum as Proposed by the American Cancer Society, Wisconsin Division . . .

THE RESULTS of this survey firmly point up the need for an all-out attack on cancer of the colon and rectum. This challenge is being met by the American Cancer Society. A major objective of the ACS is an intensified and coordinated attack on cancer of the colon and rectum during the coming year.

The PURPOSE of this program is twofold:

. . . To get more proctosigmoidoscopic examinations performed on asymptomatic patients as a part of the periodic physical examination.

. . . To have a proctosigmoidoscopic examination performed on anyone with symptoms which suggest rectal and colon cancer, or polyps.

To ACCOMPLISH the foregoing objectives it is NECESSARY that:

(a) local medical societies recognize the value of the ACS Colon and Rectal Program;

(b) individual physicians are convinced of the value of proctosigmoidoscopic examination in the detection of colon and rectal cancer;

(c) a sufficient number of physicians know how to perform the examinations, and those physicians who do not wish to perform the examination themselves are willing to refer their patients to others for the examination; and

(d) adults, especially those over 40 years of age, know of the risk of colon and rectal cancer, and understand the importance of the proctosigmoidoscopic examination and accept (or if necessary request) it as a part of their checkups and cancer detection examinations.

The Wisconsin Division President has appointed Dr. Glenn A. Smiley of Delavan Coordinator for the Colon and Rectal Cancer Program. The Medical and Scientific Committee has instructed Doctor Smiley to appoint Unit Coordinators, as any program of this nature is effective only if conducted at the community level. The job of the unit coordinator, who should be a physician, will be to supervise the chairmen of the ACS Unit's Professional Education Committee, Public Education Committee, and Publicity Committee to make certain their activities are properly timed and executed.

A training program for physicians in proctosigmoidoscopy will be offered at hospitals in key areas throughout the State prior to the massive public education program planned by the Society. For further information concerning the training programs in proctosigmoidoscopy in your area, you may contact Dr. Glenn A. Smiley directly in care of the American Cancer Society, Wisconsin Division, Box 1626, Madison, Wis. 53701.

TABLE 4—*Hospitals performing ano-bowel examinations in general adult admissions, by kind and frequency of examination*

Examination Is Performed	Type of Examination					
	Digital Rectal		Anoscopic		Proctosigmoidoscopic	
	Number of Hospitals	Per Cent	Number of Hospitals	Per Cent	Number of Hospitals	Per Cent
Routinely	17	27	1	2	1	2
Frequently	43	68	44	70	42	67
Seldom or Never	1	2	16	25	16	25
No Answer	2	3	2	3	4	6
Total	63	100	63	100	63	100

TABLE 5—*Hospitals performing ano-bowel examinations for patients with symptoms of possible ano-bowel disease, by kind and frequency of examination*

Examination Is Performed	Type of Examination					
	Digital Rectal		Anoscopic		Proctosigmoidoscopic	
	Number of Hospitals	Per Cent	Number of Hospitals	Per Cent	Number of Hospitals	Per Cent
Routinely	53	84	36	57	41	65
Frequently	9	14	18	29	20	31
Seldom or Never	0	0	4	6	1	2
No Answer	1	2	5	8	1	2
Total	63	100	63	100	63	100

vored lay education, 176 (17%) favored professional education, 322 (32%) favored lay and professional education, 83 (8%) favored neither lay nor professional education, and 113 (11%) did not reply. Thus, 81% favored some kind of educational program, and 8% did not.

HOSPITAL QUESTIONNAIRE

Response

A total of 142 hospitals outside of Milwaukee County were queried and 63 responded for a rate of 44%. The best response, 60%, was received from hospitals having 50 to 199 beds; the second best, 41%, from hospitals of 200 or more beds; and the poorest, 27%, from hospitals under 50 beds.

Findings

Table 4 shows the number and proportion of responding hospitals in which each of the three examinations are performed as part of the general adult admission examination. Seventeen hospitals, 27%, perform digital rectals, but only one, 2%, performs either anoscopy or proctosigmoidoscopy as a routine part of the examination. Nearly 70% of the respondents perform digital, anoscopic, and proctosigmoidoscopic examinations frequently, and 25% seldom or never performed anoscopic or proctosigmoidoscopic examinations of general adult admissions.

Table 5 shows the number and the proportion of responding hospitals in which each of the examinations are performed for adult hospital admissions with symptoms of possible ano-bowel disease. Digital examinations are done routinely in 84% of the responding hospitals. Anoscopy and proctosigmoidoscopy are done routinely in 57% and 65% respectively. Digital examinations are done frequently in 14%, anoscopy in 29%, and proctosigmoidoscopy in 31% of responding hospitals. Comparison of Tables 3 and 5 shows that the proportions of physicians and of hospitals reporting these examinations as being routinely performed for patients with symptoms are nearly equal.

Several questions were asked to assess the existence of professional training programs for ano-bowel disease and the potential for increasing them. Four of the responding hospitals have some type of organized training program. Fifteen additional hospitals report adequate space, equipment, and teaching staff to provide short training sessions in proctosigmoidoscopy and biopsy techniques. Fifty-seven per cent of the responding 63 staffs favored training programs to improve hospital and staff practices.

DISCUSSION

The large bowel is among the most important cancer sites. It was the leading site of cancer deaths in Wisconsin in 1965, causing 1,068 deaths. Nationally, about 73,000 cases and 43,000 bowel cancer deaths occur annually. At least two-thirds of all cancers of this site can be felt with the finger or visualized endoscopically and thus are subject to early detection. The greatest cancer control value from digital and endoscopic examinations of the

large bowel lies in performing the procedures on asymptomatic patients. The wide application of these simple facts to public, medical and hospital care practices can double survival rates for bowel cancer.

This survey tends to substantiate the impression that physicians whose medical practices relate to this subject commonly are doing digital rectals as part of their physical examinations of adults, but the more important proctosigmoidoscopic examination is infrequently done except for those adults having symptoms of possible ano-bowel disease. Hospital respondents of this survey indicated that both digital and proctosigmoidoscopic examinations are infrequently performed as part of admission physical examinations, except for those patients who present symptoms of possible ano-bowel disease. Only one out of 63 responding hospitals reported the routine doing of proctosigmoidoscopy as part of general adult physical examinations.

The surveys support the belief that lay and professional practices for ano-bowel cancer control are inadequate; indicate that medical and hospital groups are receptive to and favor organized educational and training efforts to overcome the problem; and provide information of value for the planning and functioning of program activities.

FACTS ON NEW DRUG PRODUCTS INTRODUCED IN 1966

Fewer new medicines were introduced in the United States in 1966 than in any of the previous 18 years for which accurate records are available, Paul de Haen, Inc., Drug Information Services, reported recently.

The number of prescription drug products introduced last year dropped to 80 from 112 the year before. Over a ten-year period the number of new medicines approved by the United States Food and Drug Administration for marketing has declined 80 per cent, de Haen said.

New drug products consist of single chemical agents, duplicates of existing products, combinations of existing products and new dosage forms.

Sharpest decline was in the number of single new chemical agents. The figure reached a new low of 12 after a high of 63 in 1959.

This number of single chemical agents introduced in the United States last year was lower than in any of the four major countries of western Europe, de Haen noted. Thirty-four were marketed in France, 42 in Germany, 20 in Great Britain and 21 in Italy. One-third of all these drugs were developed by American scientists.

During 1966 the American drug industry marketed in those countries seven new single chemical agents that were not available to physicians in the United States during the year, de Haen said. Two of the seven, however, were approved for marketing in this country in January 1967.

The seven drug products are: a highly potent diuretic, an antituberculosis agent, two tranquilizers, an antidepressant, an antiarthritic and a drug for anemia.

The number of firms introducing new drug products has also declined sharply, de Haen noted, from 127 firms in 1957 to 52 in 1966.

COMMENT

The figures for 1966 show a continuation of trends which have important implications for the American public. They are:

1. The decline in introductions of major new prescription drugs in the United States.
2. The increased time required by the Food and Drug Administration to act on approval of new drugs.
3. The increasing number of new drugs being marketed overseas before they are available to physicians in this country.
4. The decline in the number of American companies that are introducing new medicines. (Since the cost of pharmaceutical research is increasing—because of government regulations and because today's highly potent and effective drugs require more extensive studies prior to general release to the practicing physician—it is expected that drug research and development in the United States will eventually be conducted by fewer companies. However, the limited information from the FDA regarding the number of new drugs submitted each year for approval will make it difficult to assess the course of this latter trend.)

EMERGENCY HEART–LUNG RESUSCITATION FILM

A new film, "Prescription for Life", designed as a basic training course in emergency heart-lung resuscitation is now available from the Wisconsin Heart Association.

The film is a 16mm, color, 48-minute film produced especially for physicians, nurses and trained professional paramedical personnel. It provides detailed anatomic and physiologic experimental and clinical information covering emergency resuscitation.

The film was produced by Bondelier Films sponsored by the American Heart Association. Medical director of the film was Archer S. Gordon, M.D., of the Lovelace Clinic, Albuquerque, New Mexico.

To reserve the film, you may write the Wisconsin Heart Association's film library, 4429 W. North Ave., Milwaukee 53208, or call 414–272–4246.

THINGS A LITTLE STRAINED AT HOME??

She may be weary: women do *get weary! You spent your day-off with the utilization committee—tonight, three patients phoned during dessert alone—tomorrow night, a closed circuit craniotomy for you, Andy Griffith reruns for her. Take her away from all this!*

Make a Get-Away Weekend—just the two of you—to Prairie du Chien and the Museum of Medical Progress. Spend Saturday at the air-conditioned Museum for a delightful refresher on your colorful heritage: the dioramas of highlights; Beaumont and St. Martin; the walk-in, 1880 drugstore; the horse-and-buggy doctor. (You can make subtle remarks about how tough **his** *wife had it.)*

True, "Prairie" isn't Chicago—no Playboy Club or White Sox—or noise or dirt or rush or high prices. Instead, it's clean, restful and fun! Poke around its shops and its history. Play golf and swim. Enjoy incomparable scenery: gaze lovingly at her over a gourmet dinner of steak or fresh Mississippi fish. Go ahead. Show her what a devoted, romantic blade you still are!

The Museum of Medical Progress and Stovall Hall of Health

Prairie du Chien, Wisconsin

Owned and operated by the Charitable, Educational & Scientific Foundation of the State Medical Society of Wisconsin.

The Wisconsin Regional Medical Program
OPPORTUNITY AND CHALLENGE

By JOHN S. HIRSCHBOECK, M.D., Milwaukee, Wisconsin

ECONOMISTS PREDICT that by the mid-1970s health care will be the largest industry in the United States, exceeding agriculture and construction. The far-reaching scientific, professional, and socioeconomic changes in health care which have occurred during the past decade indicate an acceleration toward more complicated and costly considerations in the immediate future. The prospect has concerned the medical profession, public health officers, economists, social scientists, medical schools, universities, and others. One need only refer to the several provocative reports by both government and private commissions which were created to study these problems to realize that health-profession education and health care are at a critical as well as a creative moment in history.[1-5]

Congress too is aware of the problem which, in a way, it helped to create. Both Public Law 89–239, the Heart, Cancer, and Stroke Amendments to the Public Health Service Act, and Public Law 89–749, the Comprehensive Health Planning Act, provide funds for comprehensive planning of health care programs as a first step toward the implementation of the purposes behind these laws, namely the expansion and improvement of health care services through the creation of a system which will eliminate unnecessary duplications of resources and personnel, and which will close the gap between the fruits of scientific discovery and their availability to all of our people.

An understanding of the origins of these two laws is important. Public Law 89–239 has its origin in the report of the President's Commission on Heart, Cancer, and Stroke (De Bakey Commission).[2] This law as finally enacted is considerably modified from the bills originally introduced in Congress. The emphasis is now on developing cooperative arrangements among existing institutions, expanding continuing education, and planning health care programs on a regional basis rather than on creating a national network of some 32 major medical centers with satellite hospitals. The philosophy behind Public Law 89–239 comes from the background of medical educators, practicing physicians, hospital administrators, medical economists, and voluntary health agencies such as the American Cancer Society and the American Heart Association. The law has only incidental relationships to political jurisdictions and to government management. Public Law 89–749, on the other hand, is related more closely to the report of the National Commission on Community Health Services which was sponsored by the American Public Health Association and the National Health Council.[1] The philosophy behind this law comes mainly from the background of public health officers and schools of public health. Its orientation is toward using the established official agencies of the Federal and State governments to organize comprehensive health programs. Since both laws are concerned with comprehensive planning in identical or over-lapping geographical areas, one can anticipate that confusion and duplication of effort could occur unless all agencies responsible for planning in the same region collaborate enthusiastically with each other toward the same goals. Planning activity under Public Law 89–749 has been delayed because up to now Congress has not appropriated funds for its implementation.

Other planning programs in the health field in the areas of mental health, chronic disease, rehabilitation, and hospital and health facilities planning which are financed by the Federal government may exist in a state or a region. Conceivably each planning program could proceed independently without any reference to the others unless an overall region-wide approach to total health care planning had been achieved from the very beginning.

Public Law 89–239 attempts to achieve the goals of expanded and improved health care with the least interference with existing institutions. The thrust of its development is evolutionary rather than revolutionary. It seeks to accomplish its goals through voluntary means, giving full recognition to regional needs and opportunities. For this reason it is uniquely suited to provide the medical profession an opportunity to enhance its performance and improve its efficiency in providing health care.

The advantages in conducting comprehensive health planning under Public Law 89–239, the Regional Medical Program concept, are many, particularly if we wish to maintain the American health care system under local, nongovernmental control.

FIRST, the Regional Medical Program concept is based on the premise that individual, local, and regional initiative will generate plans under the leadership of the medical profession, the other health professions, citizen volunteers, medical schools, and public and voluntary health agencies. Emphasis is

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on a regional rather than a national, federal, or state organization.

SECOND, Regional Medical Programs may be in part financed but are not to be managed by the Federal government. Local responsibility is mandatory. The guidelines and regulations for Public Law 89–239 are very broad and allow maximum local autonomy.

THIRD, the Regional Medical Programs provide the opportunity for government and private agencies to collaborate with each other in developing and supporting health care programs.

FOURTH, Regional Medical Programs provide a mechanism through which university medical centers can inter-relate in education, research, and service programs with practitioners, and hospitals and clinics in the region. The emphasis on continuing education for health profession personnel is designed to bring about real participation and collaboration by practitioners throughout the region in the activities of the medical centers. As university medical centers and practicing physicians become more inter-dependent, the distinction between teacher, student, and alumnus will be less sharp, and the concept that all are members of a university will grow.

Reference is made in a recent issue of SCIENCE[6] to a book recently published in England by a former Minister of Health, Henoch Powell, entitled "A New Look at Medical Education." I quote from a review of the book in "News and Comment" in SCIENCE:

> "The analogy with the United States cannot be pushed too far. Under Medicare, the U. S. Government acts essentially as paymaster, and the organization of medicine has not been seriously affected. This differs, of course, from the situation in Britain where, under the National Health Service, the Government on the one hand operates the hospitals and employs hospital doctors and nurses, and on the other hand controls the conditions of general practice through contracts with the overwhelming majority of general practitioners."

One can hope that we in the United States will benefit from an appreciation of the difficulties created by the British system which is built on the premise of government operation by government employees. Medicare and Regional Medical Programs, although financed through the Federal government, are operated under private or quasi-public management, and in this way differ significantly from the British system.

The Wisconsin Regional Medical Program as a nonprofit voluntary corporation is not under government control, even though at present it is supported almost exclusively by funds from the Federal government. Its Regional Advisory group has a mix of governmental and private representation. This Advisory group is charged under Public Law 89–239 to guide the development of The Wisconsin Regional Medical Program. Although emphasis is given to heart disease, cancer, and stroke, planning to counteract these major diseases will inevitably relate to all of health care. The Regional Advisory group is, therefore, a body which can play a key role in determining the development of health care systems for the Wisconsin region in years to come. One of the principal goals of the Regional Advisory group is to find ways to bring about cooperative arrangements within the entire social and governmental structure.

The problems of manpower shortage and the ever-widening gap between the accumulation of knowledge and its application to people should be given primary consideration by the Regional Advisory group and the staff of The Wisconsin Regional Medical Program. The expansion and improvement of continuing education for the health professions is one way of dealing with both problems. Innovative and time-saving methods for providing continuing education need to be developed. Fortunately The Wisconsin Regional Medical Program is in a favored position because of the existing strong programs which are now sponsored by the State Medical Society of Wisconsin, the medical schools, and voluntary health agencies.

The task lying before us may seem to be incredibly difficult. Fortunately we have the resources of systems analysis and operations research to aid in planning. It, perhaps, appeared difficult to engineers in the telephone industry when they set about planning a system whereby a person might dial directly within a few moments to any other telephone in the United States. The prospect of bringing independent private corporations such as the American Telephone and Telegraph Company, the General Telephone Company, and literally hundreds of smaller regional and rural telephone companies, on the basis of cooperative arrangements, into a system which could provide instantaneous communication must have been very challenging, and yet direct-dial distance telephoning was achieved. Providing health care is admittedly infinitely more complicated. Nevertheless, this should not deter us from using the capability which is available in The Wisconsin Regional Medical Program to achieve our goals.

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SPECIAL TO THE JOURNAL

Project 6—Pilot Program for Rural Retarded

By JOHN B. TOUSSAINT, M.D. and ANN CLEELAND, Madison, Wisconsin

PROJECT 6 is a pilot program to stimulate the development of community services for the mentally retarded in a rural area by providing consultative guidance and partial financial aid. Officially known as "The Community Services Demonstration Project for the Mentally Retarded in Southwestern Wisconsin," it is administered by Central Wisconsin Colony and Training School, Madison. The project began July 1, 1964, under a U. S. Public Health Service contract and continued under a five-year grant beginning July 1, 1965.

The project is based on the idea that the retardate probably can develop his maximum potential in his own home where he can receive the individual attention and affection of his parents. Moreover, the taxpayers benefit because they do not have to bear the cost of supporting a child in an institution. A retarded individual should be institutionalized only when his needs cannot be met in his community. However, development of community services for the retarded in rural areas has been extremely slow.

To find the problems which exist and to demonstrate means of overcoming these problems, the project selected six counties—Grant, Lafayette, Iowa, Richland, Crawford, and Sauk. This area was chosen because it possessed the typical obstacles—inherent in rural areas—of low population density creating communication and transportation difficulties, and of extreme shortage of professionals and public agencies equipped to deal with retardation. Aside from a few special education classes, this area had none of the services considered necessary for the care of the retarded. Thus, Project 6 launched a 10-point program which is presented here.

PUBLIC EDUCATION

The understanding of the retardate's needs and the subsequent impetus to serve him suffer in rural areas from a lack of information about retardation. Project 6 is providing this information to the public through its newsletter and slide program and through the involvement of local parents, libraries, and news media in the dissemination of information. The newsletter's initial circulation of 250 in September 1965 has climbed to 1,350, and the slide program has been viewed by more than 3,000 persons. The program has stimulated many local civic groups to ask what they may provide for the retarded in their areas.

Stimulated by the project, parents of retarded children are now organized in all six counties under the Wisconsin Association for Retarded Children. These parents are discussing problems they have in common in caring for their retarded children. They also are playing an integral role in the project by helping to publicize the need for more community resources for the retarded.

PROFESSIONAL AND AGENCY INFORMATION

Since professional people often play a vital part in the referral of the retarded, it is important that they be kept informed of the project's activities. The project sends information on retardation and the new services being developed to the 95 general practitioners, 205 clergymen, 125 lawyers and judges, 68 dentists, 53 school administrators, and 41 special education teachers in the area. Also kept informed are welfare workers, public health nurses, and the agencies which deal with the retarded. In addition, seminars on the direct relationship between retardation and their particular profession have been conducted for most of these groups.

FIXED POINT OF REFERRAL

In each county the project has set up a fixed point of referral, a kind of middle-man to whom the retarded can be referred and who, in turn, will refer the retarded to the appropriate services. This source of information is necessary in a rural area where the appropriate service is hard to find. The following are acting as the fixed points of referral in their county; Lafayette—the sheltered workshop in Shullsburg; Grant and Sauk—the mental health clinics; Richland—public health nurse; and Crawford and Iowa—the county welfare departments. The project provides a 20% subsidy to the agency for the salary of the staff member acting as the fixed point of referral, along with consultation and training for the individual and assistance in publicizing his existence to the public.

Doctor Toussaint is Clinical Director at Central Wisconsin Colony and Training School. Mrs. Cleeland is Public Information Writer for Project 6.

LOCAL DIAGNOSTIC SERVICES

In rural areas there is an inevitable shortage of professionals available to evaluate a person suspected or known to be retarded. The project, therefore, established a traveling diagnostic team comprised of a pediatrician and a psychologist. As of May 1, the traveling team had seen 154 area children suspected of being retarded. Psychological testing showed that 109 children had various degrees of retardation. There were also 9 children in the dull-normal range and 11 with emotional problems. Physical examinations revealed such disorders as cerebral palsy, minimal brain damage, mongolism, seizures, and multiple congenital anomalies. The team counsels the parents and recommends the appropriate services, while the fixed points of referral assist the parents in obtaining these services. Parents have expressed great satisfaction with the evaluation and counseling, and a majority of the children have been placed in the recommended program or seen by the recommended agency.

In addition to the traveling team, a dental service was developed. Local dentists found retarded children difficult to treat because most of these children need general anesthesia before dental work can be done. To provide this service, an outpatient dental clinic was set up at Central Colony to which local dentists can refer these children.

HOME TRAINING SPECIALIST

To help enable parents to keep their retarded child at home, the project has a specialist who provides in-the-home training and counseling. The home training specialist, who currently is working with 73 retarded children, helps with problems such as feeding, toilet training, ambulation, and discipline. She counsels parents on how to teach and provide recreational activities for their child, and she provides them with instructional material and special equipment. By working with the fixed points of referral and consulting with Central Colony specialists, the home trainer determines the child's readiness for activities and acts as a liaison between the parents and the community programs needed by their child.

COMMUNITY PLACEMENT WORKER

There are 187 patients in the three Wisconsin Colonies who have legal residence in the project area. Due to the increased number of services in the area which can now serve them, the community placement worker is evaluating these patients to identify those who might be able to return to their community, either to their own home, foster home, or nursing or county home. The placement worker is also developing a program of short-term care homes which can stand by to care for a retarded child in a family emergency, thereby possibly preventing institutionalization.

SPECIAL EDUCATION

When the project began, there were only about four classes per county for the educable (mildly retarded) and only one class in the entire area for the trainable (moderately retarded) child. The Bureau for Handicapped Children requires psychological evaluation of an individual to be placed in a class before subsidy to the school can be authorized. Psychological services were not available in these school systems, and the Bureau's testing facilities required a long waiting period. Therefore, the project employed two psychologists to do the testing. About 290 children were evaluated for special classes through the project, and 148 were found to be retarded. The testing also disclosed children presenting problems such as specific learning disabilities and emotional disturbances. These children received proper referral. Eventually, a local agency, the district Cooperative Educational Service Agency (CESA), took over the testing. The 19 district CESA's in Wisconsin, set up by the State Department of Public Instruction in 1965, are agencies through which schools can purchase specialized services. Thus, evaluations for special classes are now being accomplished through a local agency which uses local school district funds and employs psychologists from Platteville State University to do the testing.

A program on "Teaching the Mentally Retarded Child," held at Central Colony for school administrators and special class teachers from the project area, stimulated interest in setting up more special classes. Partially as a result of this interest, the number of special classes has doubled. The solution to the problem of a shortage of special class teachers seems imminent as local high school students are encouraged to consider the field. If plans proceed, Platteville State University will develop a training program in special education for these students.

DAY CARE PROGRAMS

Through the work of local parent and civic groups, fixed points of referral, and the project, eight day care centers for the retarded are now functioning. In these centers, which have a total enrollment of 55, children are learning to improve basic motor and social skills. The more capable are prepared for entrance into special classes. The day care centers are located in Prairie du Chien, Lancaster, Cuba City, Reedsburg, Richland Center, Baraboo, Boscobel, and Platteville. Six of these centers have developed the standards necessary to receive state matching funds. The centers in Grant and Crawford counties are now financially independent of the project.

SHELTERED WORKSHOP

A sheltered workshop was set up in Shullsburg through the work of the Lafayette Association for Retarded Children with the help of project funds

and consultants. The Association turned a pioneer lead mine into the Badger Mine and Museum, a tourist attraction which finances programs for the retarded and helped get the workshop on its feet. The workshop budget is now supported by the state. Serving four counties and accepting referrals from the other two in the project area, the workshop has had 34 clients ranging from 16 to 52 years old. Thirteen of these have been placed in active employment outside the workshop. There are now 10 mentally or physically handicapped persons, who do jobs such as sewing and handicrafts, in the workshop.

RECREATION

In order to stimulate interest in recreation for the retarded, the project presented a seminar on camping for the retarded, held in March 1966 at Platteville State University. The result of this seminar was local support of a free camp for 58 retarded children held in August at Wyalusing State Park. The children participated in outdoor activities, crafts, and nature studies. The 1967 camp will be held August 6–18 at Wyalusing. With the program extended to two one-week sessions in order to accommodate retarded adults as well as more children, 130 campers can be served.

* * *

In every objective established for the project, there is active community involvement, both personal and financial. In the future, problems will be worked out, new ideas will be tested, and further community support will be developed in preparation for the phasing-out of the project. In addition evaluations of the programs are now being undertaken. For instance, a thorough study is being prepared on the mental health clinics, county welfare departments, public health nursing service, and sheltered workshop to determine which one functions most efficiently as the fixed point of referral. Such evaluations will provide ideas for other areas considering similar programs. Information on Project 6 has been requested from many Wisconsin regional and state agencies, 28 other states, Canada, and Switzerland. Those wishing further details may contact Paul Ansay, Project Coordinator, Central Colony, Madison, Wis. 53704.

WISCONSIN'S HEALTH by E. H. JORRIS, M.D., State Health Officer

DENTAL CARE FOR THE HANDICAPPED

Dr. M. C. Arra, director of the Division of Dental Health of the State Board of Health states that better dental care for handicapped children will be a result of a project of the Wisconsin State Dental Society in cooperation with the State Board of Health, the Marquette University School of Dentistry, and Children's Hospital in Milwaukee.

A 4-day course in dentistry for handicapped children was presented at Children's Hospital during January. Instructors and lecturers for the course were dentists, physicians and other specialists experienced in meeting the dental, medical and emotional conditions encountered in handicapped children, particularly those who have cerebral palsy, mental retardation, muscular dystrophy, multiple sclerosis or cleft palate.

It is often difficult to arrange for dental care for children who suffer these handicaps without traveling some distance. Need for emergency care can create a crisis.

The course was prompted by the recognition that most dentists in general practice have the professional skill to care for the dental health of handicapped persons but lack the knowledge of the peculiar problems encountered in the various handicapping conditions. When the course for practicing dentists on "dentistry for handicapped children" was announced there were about four times as many applicants as could be accommodated in the limited class. To assure greater availability of the skills taught in this course class members were selected from geographical areas of the state.

Parents of children who suffer the handicaps mentioned here and who would like the name and address of the specially trained dentists nearest to them may obtain this by writing the Wisconsin State Dental Society, 633 W. Wisconsin Ave., Milwaukee, Wis. 53203.

* * *

BOOKLET: SPACE TECHNOLOGY

A booklet describing 29 special reports on space technology of potential use in other industries has been issued by the National Aeronautics and Space Administration.

The publications describe new concepts, designs, techniques, materials, processes, equipment, and products. Most are addressed to engineers, managers, and physicians. They were published by the NASA Office of Technology Utilization as part of a program to make the results of space research quickly available to users in other fields.

The booklet, entitled "Useful New Technology," is available on request from the Technology Utilization Division, Code UT, National Aeronautics and Space Administration, Washington, D. C. 20546. The publications listed in it are on sale from the Clearinghouse for Federal Scientific and Technical Information, Department of Commerce.

SPECIAL TO THE JOURNAL

The Future of Nursing Education

THE FOLLOWING ARTICLE has been written by the Wisconsin Nurses Association Ad Hoc Committee on the Future of Nursing Education and is being presented as a means of bringing information and the profession's thinking about nursing education programs to Wisconsin physicians.—EDITOR

"EDUCATION OF THOSE who work in nursing should take place in institutions of learning within the general system of education." This position, developed by the Committee on Education of the American Nurses' Association, first appeared in the December 1965 issue of THE AMERICAN JOURNAL OF NURSING.[1] At the ANA convention in June 1966, the House of Delegates overwhelmingly supported The Position Paper by commending the committee and the ANA Board of Directors for their foresighted action in developing the statement.

The Position Paper has stimulated much concern and some controversy among nurses and others. Much of the disagreement over the position taken by the American Nurses' Association appears to be generated by a lack of understanding of both the content and the purpose of the paper. This article was written to aid physicians in their understanding of current developments in nursing education relating to The Position Paper.

In brief, The Position Paper defines two types of nursing practice on the basis of education: professional and technical. It is obvious that the nursing needs of people cannot be met by the professional practitioner alone; supporting personnel with a considerable understanding of nursing theory and a high degree of technical skill are seen as essential to augment the service of the professional nurse.

The implications in The Position Paper can best be understood by relating them to pertinent social and economic trends in our society, for nursing education cannot be separated from general education. A brief review of the history of nursing education also helps clarify current developments.

When Florence Nightingale established the first modern school of nursing in the world at St. Thomas' Hospital in London in 1860, she established an independent school, separate from the hospital. This important educational aspect of the "Nightingale system" was lost when her ideas crossed the ocean to this country.

It must be remembered that when Miss Nightingale's school was established, women were not educated in public institutions. Obviously, at that time nursing education could not have been established in the system of higher education. When the first schools of nursing were created in the United States in 1873, patterns of public education were not yet well established.

Our system of land-grant colleges has provided many educational opportunities to both men and women. In addition, this country has had the foresight to provide more advantages to women, so the establishment of nursing programs in collegiate settings was a logical development here. The University of Minnesota is credited with initiating the first collegiate nursing program in 1909.

Hospitals early recognized that student nurses provided much care to patients at a very low cost, and diploma schools of nursing increased rapidly. By 1920, there were over 3,000 schools of nursing in this country. This rapid expansion of schools of nursing was possible since there were no established educational standards for nursing—a situation comparable to the one that existed earlier in medicine with the "diploma mill" medical schools, prior to the Flexner report.

The exploitation of nursing students during this period of time was widespread: students worked long hours, with classes superimposed on inhumane schedules. Usually a minimal number of classes was taught; often the faculty consisted of one nurse, frequently an already-overworked director of nursing, with a few additional lectures from busy physicians who donated their time and services.

The situation changed as licensing laws for the registration of nurses were passed.[1] Requirements for registration included regulations pertaining to the student's education, and slowly the quality of nursing education improved.

Initially, the development of collegiate schools of nursing was rather slow. Several factors account for this: hospital diploma schools were well-established by the time collegiate nursing programs were inaugurated; collegiate education was very expensive compared to hospital schools; university faculties were reluctant to accept nursing as appropriate for collegiate education. Expansion of baccalaureate programs in nursing did not come until after World War II; it is closely related to the general increase in numbers of people seeking higher education.[2]

The issues involved in changes in traditional patterns of education are not simple ones. Drastic changes are occurring in education today, and nurs-

[1] Copies of "Educational Preparation for Nurse Practitioners and Assistants to Nurses—A Position Paper" are available at 50¢ each from ANA Headquarters, 10 Columbus Circle, New York, N. Y. 10019.

[1] In Wisconsin, the Nursing Practice Act was passed in 1911.

[2] The University of Wisconsin School of Nursing, Madison, was established in 1924. Marquette University College of Nursing dates to 1936, at which time the college took over St. Joseph's Hospital School of Nursing (established in 1899). Other collegiate programs in Wisconsin: Alverno College, Milwaukee; Marion College, Fond du Lac; University of Wisconsin–Milwaukee; Wisconsin State University–Eau Claire. Programs are being planned for Wisconsin State University–Oshkosh and Viterbo College, La Crosse.

ing cannot escape being touched by them. With this background, we will now look at the specific proposals in The Position Paper.

THE PROFESSIONAL NURSE

"Minimum preparation for beginning professional nursing practice at the present time should be baccalaureate degree education in nursing."

This proposal in The Position Paper suggests more education for the nurse beginning professional practice. The proposal suggests that nursing practice requires a broader type of preparation than most nurses have had. There are many reasons for this proposal.

Every physician knows that medical science is undergoing a revolution, related to the rapid advance of technology that is taking place. The impact of medical advances depends upon the support of many others working in close alliance with the physician. The nurse is only one of these professionals, but he's an important one, and he must be prepared to work effectively as a member of the health team.

There is little doubt that nursing in the future will be more highly technical and specialized. The nurse of the future will require a broader educational background to cope with the complexities of nursing practice and provide the quality care that a better informed public will expect and demand.

It can be assumed that the nurse will be expected to accept much greater responsibility in the care of patients. This has been the pattern that has been evolving since about the turn of the century, when the nurse first became entrusted with the clinical thermometer. This trend will no doubt continue, if for no other reason than sheer numbers of people requiring health care. Over the years, there has been a trend toward an increasing proportion of nurses per population, and at the same time a decreasing number of physicians. It seems apparent that under these circumstances, nurses will be expected to perform in different ways than previously.

The practice of nursing itself will change, as medicine advances. New vaccines and other preventive measures are effective only to the extent they are used: nurses have an important role in prevention. People must learn to live with their chronic illnesses: nurses have a significant role in teaching and assisting the therapeutically well to live with their limitations.

Now and in the future, the care of patients will extend beyond the hospital walls. In a lifetime, a person may spend only a short time in the hospital. Nurses will require a broader type of education to prepare them for a different role in caring for patients in a variety of settings: hospitals, outpatient departments, doctors' offices, nursing homes, schools, places of employment, and their own homes.

Society will place greater demands upon all practitioners in the field of health. As the standard of living continues to rise, we find increasing demands for better health care. Nurses must be educated in ways to help meet these increasing demands.

Because nursing is primarily a woman's occupation, it should be noted that a higher percentage of women are getting married today than formerly, and they are being married at an earlier age. This trend has had a marked effect on nursing service, and has implications for nursing education.

Many women will leave the practice of their profession for varying periods of time. Increasingly, the education of nurses will encompass methods for keeping updated during periods of inactivity. However, their education ought to have prepared them to be effective persons and responsible citizens as well as competent nurses. Educational institutions are more likely to provide for this. Can hospitals afford to provide this type of education? And if they don't, are students being educationally shortchanged?

THE TECHNICAL NURSE

The Position Paper states, "Minimum preparation for beginning technical nursing practice at the present time should be associate degree education in nursing."

The technical nurse is prepared to function as a general nurse practitioner, and may fill the staff position in all areas of nursing service.

Two-year associate degree programs in nursing were initiated in 1952. At the present time these courses of study are increasing at a more rapid rate than any other type of nursing program. In 1966, there were about 160 community colleges offering nursing.

The rapid expansion of the two-year program in nursing is associated with the rapid development of two-year community colleges throughout the nation. Wisconsin has been slow in this development; the only two-year nursing program in the state was inaugurated at the Milwaukee Institute of Technology in September 1965.

Community colleges, which are tax-supported and usually provide education at minimum expense to the student, have among their objectives that of providing post-high school education in technical fields. Out of this objective the concept of a "technical nurse" has developed.

The preparation of this nurse combines college courses with clinical nursing practice. The practice is in one or more hospitals with which the college has an agreement, but the control of the student's education rests with the college. Obviously, the selection of a hospital for clinical practice for the student is a matter of importance to the student's education.

AUXILIARY PERSONNEL

The last recommendation in The Position Paper relates to the training of auxiliary workers:

"Education for assistants in the health service occupations should be short, intensive preservice

programs in vocational education institutions rather than on-the-job training programs."

In addition to the services of nurse practitioners, people in need of health services require assistance of less skilled workers. These workers have long been employed in hospitals; most recently they have been employed in other types of organized health facilities, such as public health agencies. This expansion of services means that on-the-job training courses are no longer adequate nor appropriate for training this group of workers. The proposed plan of education does not preclude supervised practice in the clinical setting; indeed, it suggests the great need for more adequately prepared nurses. The supervisory nurse will require a broad understanding of the needs of patients as well as the personnel if effective care is to be given.

Hospitals expend vast amounts of time, effort, and money in the training of auxiliary personnel. The statement suggests that some of this vocational training could be done by educational institutions. Not all the training, particularly those aspects relating to job-readiness, needs to be done by nurses. It is recognized that workers assigned to nursing services must be given adequate orientation and on-the-job training.

POSITION OF THE STATE BOARD OF NURSING

The recommendations in the ANA Position Paper suggest some drastic changes from current educational practice. It is recognized that an orderly progression is necessary to assure that patients receive the care they require. Therefore, the Wisconsin State Board of Nursing issued the following statement relating to The Position Paper:

> "The Wisconsin State Board of Nursing recognizes that the American Nurses' Association's first position on education for nursing will have implication for nursing education, nursing practice, nursing service and the training of auxiliary workers in Wisconsin. It also recognizes that economic pressures on hospitals and other developments in society are increasing the movement of nursing education programs into the colleges and universities, the loci of education for all other professions.
>
> "While change in education for nursing is inevitable, the Wisconsin State Board of Nursing recognizes that orderly planning for change to insure an uninterrupted flow of nurses into the community is essential. To this end it (1) supports all of its present programs in nursing; (2) believes that a desirable balance of nursing personnel with various kinds of preparation must be maintained; and (3) opposes the termination of any program until such time as the community has established a new program in nursing which will provide for an uninterrupted flow of nurses."

POSITION OF THE WISCONSIN NURSES ASSOCIATION

After study of The Position Paper the Board of Directors of the Wisconsin Nurses Association voted to endorse it and to support the Wisconsin State Board of Nursing position on nursing education, "recognizing that while change in education for nursing is inevitable, it is also desirable."

An Ad Hoc Committee on the Future of Nursing Education[1] in Wisconsin was appointed by the WNA Board to (1) study The Position Paper in light of the future of nursing education in Wisconsin; and (2) investigate ways and means of implementing an orderly transfer of nursing education programs.

ENROLLMENTS IN SCHOOLS OF NURSING

Any discussion of The Position Paper includes a consideration of enrollments of schools of nursing. Enrollments in Wisconsin diploma programs have dropped, related in part to the closing of three of these programs. It will take a little time for enrollments in the new collegiate programs to make up the difference.

National statistics provide a hopeful picture. The following statement from the November 1966 *Employment Service Review*,[2] is significant:

"Statistics for the last 10 years provide a hopeful sign that, as nursing education becomes campus based, more qualified young people will choose nursing as their profession. From 1955 to 1965, total enrollments in baccalaureate nursing programs increased from 20,883 to 30,378, while at the same time diploma school enrollments were dropping off slightly from 94,812 to 93,760. The phenomenal gain was in the associate degree programs, with enrollments moving from 1,084 to 11,540."

SUMMARY

The Position Paper on Nursing Education of the American Nurses' Association states that "education for those who work in nursing should take place in institutions of learning within the general system of education." It defines two types of nursing practitioners for the future: the professional nurse with a baccalaureate preparation and the technical nurse, prepared in the community college.

The suggested changes in nursing education relate to general social and economic trends in our society. If the nursing profession does not keep pace with the knowledge explosion, the new technology, the changes in our society, patients will not receive quality nursing care. Likewise medical care will suffer if nursing does not keep pace with current developments. Every physician has a stake in the future of nursing education.

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[1] Members of the Ad Hoc Committee are: Mrs. Janet Nusinoff, Chairman, Winneconne; Margaret MacLean, Elkhorn; Mrs. Signe S. Cooper, Middleton; Mrs. Betty Jameson, Sister M. Renelle and Mrs. June Tyler, Green Bay; Sister Grace Clare, La Crosse; Geraldine Busse, Mabel L. Johnson, and Beatrice K. Palen, Madison; Mrs. Mary Vick, New Berlin; Helen L. Brunclik, Marshfield; Sister Mary Agreda, Fond du Lac; and Mrs. Myrtle Buettner, Menomonee Falls.

[2] U. S. Department of Labor, available from the Superintendent of Documents, U. S. Government Printing Office, Washington, D. C., 20402; price 40¢ (single copy).

nursing care for cancer patients–

...a major concern for their families, *and* for their physicians. In a unique pioneering service, the American Cancer Society is deeply involved in finding a solution.

Recognizing the phenomenal growth of nursing homes—aware of the shortage of nurses—knowing the implications of the extended care benefits of Medicare—the Society has launched a dramatic educational demonstration project on cancer nursing for nursing home staff. Special emphasis is on colostomy irrigation, care of the laryngectomized patient, care of an ileal bladder, and emergency nursing. To achieve maximum application of this plan, a cadre of nurses is being trained by the Society to conduct cancer nursing courses in nursing homes throughout the nation.

This endeavor has been warmly endorsed by the American Nurses Association and other professional organizations. We feel sure that such a program, bringing skilled nursing care to the bedside of the cancer patient, will be enthusiastically received by the medical profession.

AMERICAN CANCER SOCIETY ®

THIS SPACE CONTRIBUTED BY THE PUBLISHER

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THE COUNCIL—State Medical Society of Wisconsin

MARCH 12, 1967: Seated around the Council table, left to right, are: W. R. MANZ, M.D., Eau Claire, councilor—10th district; Marvin Wright, M.D., Rhinelander, c—13th; G. J. Schulz, M.D., Union Grove, c—1st; W. J. Houghton, M.D., Milwaukee, c—12th; L. J. Van Hecke, M.D., Milwaukee, c—12th; J. H. Houghton, M.D., Wisconsin Dells, past president; E. J. Egan, M.D., Milwaukee, c—12th; E. P. Ludwig, M.D., Wausau, c—9th; P. B. Blanchard, M.D., Cedarburg, c—5th; F. E. Drew, M.D., Milwaukee, president; E. J. Nordby, M.D., Madison, vice-chairman and councilor—3rd; W. D. James, M.D., Oconomowoc, c—1st; S. L. Chojnacki, M.D., Milwaukee, c—12th; M. D. Davis, M.D., Milton, c—3rd; C. A. Grand, M.D., Ashland, c—11th; J. W. Boren, Jr., M.D., Marinette, c—8th; C. W. Stoops, M.D., Madison, c—3rd; S. W. Hollenbeck, M.D., Milwaukee, c—12th; J. E. Dettmann, M.D., Green Bay, c—6th; and R. E. Callan, M.D., Milwaukee, speaker of the House of Delegates. Others who were not present for the picture are: J. C. Fox, M.D., La Crosse, chairman and c—7th; H. W. Carey, M.D., c—4th; J. A. Sisk, M.D., Fond du Lac, c—6th; and H. J. Kief, M.D., Fond du Lac, president-elect.

AMA delegates, staff members, and consultants are shown around the Council table, left to right: (seated) J. M. Bell, M.D., Marinette, delegate to AMA, and C. J. Picard, M.D., Superior, alternate delegate to AMA; (standing) D. E. Gill, C.P.A., and J. B. White, C.P.A., Madison, accounting consultants; H. O. Brower, Madison, special assistant to the Secretary; T. H. Murphy, Madison, public information director; W. J. Brown, Chicago, Ill., AMA field representative; H. B. Maroney, Madison, executive assistant; L. A. Johnson, Madison, accounting and membership services; J. F. Miller, Madison, assistant building manager; N. J. Salt, Madison, director of C.E.S. Foundation; R. B. Murphy, Madison, general counsel; J. A. Kluwin, Milwaukee, associate general counsel; R. E. Koenig, Madison, insurance director; C. H. Crownhart, Madison, secretary and general manager; and D. C. Reynolds, Madison, director of scientific services; (seated) Joan Pyre, Madison, committee secretary; Jean Anderson, Madison, personnel director; N. A. Hill, M.D., Madison, alternate delegate to AMA; and E. L. Bernhart, M.D., Milwaukee, delegate to AMA.

Minutes of Council Meeting

MADISON, MARCH 11–12, 1967

1. Call to Order and Roll Call

The meeting was called to order by Chairman Fox at 2:00 p.m. on Saturday, March 11, 1967, at the State Medical Society.

All voting members of the Council were present Saturday afternoon. Absent Saturday evening were Doctors Nordby and Stoops, and absent Sunday morning were Doctors Sisk and Fox.

Others present were President-elect Kief; AMA delegates and alternates Bell, Bernhart, Hill, Picard, and Collentine (Saturday only); Doctors Stovall and Dessloch on Saturday; Messrs. Crownhart, Koenig, Reynolds, Brower, T. H. Murphy, Salt, Johnson, Kluwin, Gill, White, Tiffany (Saturday), W. J. Brown; Mrs. Anderson and Miss Pyre. Present on Sunday only: Messrs. R. B. Murphy, Maroney and Miller.

Members of the Wisconsin Academy of General Practice registering attendance for special order on Saturday: Drs. Jack Brown, N. G. Bauch, E. M. Kay, H. M. Klopf, C. L. Berner, J. S. Devitt, G. J. Derus, D. J. Heyrman, E. L. Bernhart, J. M. Bell, H. J. Kief, W. D. Hamlin, R. F. Purtell, C. J. Picard, S. E. Zawodny. Members of the Wisconsin Surgical Society present: Drs. A. G. Martin, R. P. Sinaiko, J. T. Mendenhall, and C. M. Schroeder.

2. Approval of Minutes

On meeting of Doctors Chojnacki–Ludwig, carried, minutes of the Oct. 21, 1966, meeting were approved as published in the JOURNAL with approval of the chairman.

3. Special Order—Implications of Action by Hospital Boards of Directors Affecting Hospital Staff Privileges

Doctor Bernhart for general practice and Doctor Martin for surgery spoke to the subject, with references to the resolution adopted by the House of Delegates in October 1966 reaffirming a policy of the AMA on ethical considerations of general practitioners participating in surgical procedures, and specific action by one hospital board and proposed action by another to impose restrictions in the matter of surgical assistants.

There was a period of discussion in which Council members were afforded opportunity to ask any questions they had, and the Chairman announced that the Council would take action later in the meeting.

When the Council reconvened after dinner recess, Doctors Hollenbeck–Schulz introduced a resolution which was laid over to Sunday morning and adopted then in the following form:

> "WHEREAS, It has been brought to the attention of the Council of the State Medical Society of Wisconsin that certain hospitals, through action by their governing boards, have unilaterally changed or propose to change the constitution and bylaws of said institutions by curtailing or abrogating the privileges of many staff physicians; and
>
> "WHEREAS, It appears that said action may be detrimental to good medical practices; now, therefore, be it
>
> "*Resolved*, That (1) the Council of the State Medical Society of Wisconsin disapproves of such actions; and (2) the Chairman of the Council is hereby authorized to appoint a five-man committee composed of the President-elect of the State Medical Society, the Vice-chairman of the Council, and three members of the Council, assisted by legal counsel of the State Medical Society, to meet as soon as practicable with the authorized representatives of said hospitals in an attempt to arbitrate the existing problem."

On motion of Doctors J. H. Houghton–Chojnacki, carried, the subject was withdrawn from the Commission on Hospital Relations and Medical Education in light of establishment of a special committee.

4. Report of Executive Committee

The committee reported the following matters for Council information or action:

A. Commission on State Departments

(1) On motion of Doctors James–Ludwig, carried, the Council elected George Stebbins, M.D., as chairman of the Division on Aging.

(2) On motion of Doctors Nordby–Chojnacki, carried, the Council appointed E. S. Houfek, M.D., as vice-chairman of the Division on Nervous and Mental Diseases.

(3) On motion of Doctors Chojnacki–Ludwig, carried, the Council approved separation of the Division on Visual and Hearing Defects, following upon action to create separate scientific sections for the specialties of ophthalmology and otolaryngology.

B. Osteopathy

On motion of Doctors Chojnacki–Blanchard, carried, the Council approved a suggested model bylaw for distribution to Society members for consideration by the boards of hospitals with which they are affiliated that choose to entertain applications for staff membership from doctors of osteopathy.

C. Council Award

It was reported for the record that a unanimous vote by mail ballot was received on the nominee of the Executive Committee.

D. Presidential Citation

On motion of Doctors Blanchard–Grand, carried, the Council unanimously approved the nominee of President Drew.

E. Future Annual Meeting Location

On motion of Doctors Egan–Chojnacki, carried, the Council approved action of the Executive Committee in committing utilization of convention facilities in Milwaukee through 1970 in order to avoid losing them to other organizations desiring to tie them up at the same time of year.

F. Section on Ophthalmology

On motion of Doctors J. H. Houghton–James, carried, the Council approved collection by the Society of voluntary contributions of members of the section on ophthalmology and segregated ac-

counting to them in the general categories of support to public education, support to legislative and other proposals of the ophthalmologists, and direct and indirect costs of special mailings.

G. Commission on Hospital Relations and Medical Education

On motion of Doctors Chojnacki–Blanchard, carried, the Council confirmed President Drew's appointment of L. W. Schrank, M.D., Waupun, to a vacancy on this Committee.

H. Reference Committee on Finances

On motion of Doctors Callan–Egan, carried, the Council approved submission of an amendment to Chapter III, Sec. 4 of the Bylaws, adding a reference committee on finances to the committees enumerated in that section.

On motion of Doctors Hollenbeck–Chojnacki, carried, the Council disapproved a recommendation of the Executive Committee that a further amendment be introduced to the effect that additional reference committees recommended by the Speaker to be necessary be brought to the Council for approval.

I. Proposed Study by Division on Maternal and Child Welfare

The Council accepted a staff report on a joint study which this division proposes to conduct with the State Board of Health and the Wisconsin Hospital Association on the adequacy of hospital facilities and professional training to handle obstetrical emergencies.

J. Health Service Data of Wisconsin, Inc.

The Council approved the appointment of James A. Sisk, M.D., as the Society representative in this corporation whose purposes had previously been discussed.

K. Interagency Council on Smoking and Health

The Council approved the appointment of Ralph Frank, M.D., as the Society's representative on this council organized by the State Board of Health.

5. 1966 Membership Report

On motion of Dr. W. J. Houghton, seconded and carried, the Council authorized recertification by the Secretary of the number of delegates and alternates to which certain county medical societies are entitled based on year-end membership count and the revised method of allocation.

6. Maternal Mortality Study Committee

Staff reported that a special study under consideration by a subcommittee would first be explored further with the Division on Maternal and Child Welfare before asking Council approval.

7. Nursing Liaison Committee

On motion of Doctors Chojnacki–James, carried, the Council designated the Commission on Hospital Relations and Medical Education as the body within the Society structure to act as a liaison committee with nurses.

8. House of Delegates Reports

A total of twelve reports had been distributed to the Council, but not with sufficient time for adequate prior review by members. It was concluded that rather than review them in detail during the meeting, they be circulated to the House of Delegates and if the Council found that it wished to make any specific comments, it could do so in May.

It was moved by Doctors Nordby–Schulz, carried, that the reports be forwarded to the House of Delegates.

9. Annual Report on Conflict of Interest Procedure and Compliance

The Secretary reported that pursuant to the procedure adopted to meet the requirement of the Wisconsin Insurance Commissioner, all councilors, officers, members of the Commission on Medical Care Plans, and responsible staff members have signed the certificate form on conflict of interest.

10. Utilization Review Committees

The Council discussed a communication from a physician in behalf of a hospital staff in Wisconsin asking that consideration be given to the Society seeking legislative immunity from litigation for physicians serving on such committees under P.L. 89–97. Mr. Kluwin reminded the Council of contacts he had previously reported to the end that there was general agreement that professional liability insurance protected physicians serving in this capacity.

On motion of Doctors Nordby–Carey, carried, the Council agreed that such immunity not be sought by legislative means.

11. Wisconsin Association of Professions

Mr. Brower reported for information on the success to date of the member organizations in enrolling individual members in this association.

12. Councilors and Officers Newsletter

The Secretary reported that with approval of the Executive Committee, the office would reinstitute circulation of a Councilors and Officers Newsletter in a further effort to facilitate communication to a representative group of members of official actions, news items, and the like.

13. Proposal on the Matter of Health Careers

The Secretary outlined in general a proposal for further development by the Planning Committee that the Society take the initiative in having proclaimed a Health Career Week for high schools and see that appropriate programs are presented with the assistance of the Auxiliary and other groups. If found feasible, there might also be in this connection a supplement or special issue of the WISCONSIN MEDICAL JOURNAL.

14. Fees for Surgical Assistants

The board of directors of The Medical Society of Milwaukee County had requested that the councilors of that district have the Council consider a proposal by Surgical Care to establish a 20 per cent fee schedule for surgical assistants.

On motion of Doctors Hollenbeck–Manz, carried, the Council concluded to reply by suggesting that to help the situation, Surgical Care pay usual and customary fees.

The Council had recessed for dinner before the preceding item. After discussing and laying over the resolution on hospital staff privileges, it recessed at 8:10 p.m. and reconvened Sunday morning, March 12, Doctor Nordby presiding.

15. Kellett Reorganization Bill

On motion of Doctors Van Hecke–Chojnacki, carried, the Council approved a communication to the Governor stating the Society's position on this legislation as currently amended.

16. Legislative Report

Mr. Murphy discussed the status of federal and state legislative proposals of particular interest to the Society.

Doctor Van Hecke suggested that the Division on Safe Transportation consider the question of the Society taking a position on medical grounds on the minimum legal drinking age.

17. Report of the Secretary

Mr. Crownhart informed the Council of the appointment of Mr. Robert Heider as additional legislative counsel on special assignment.

Discussion of his recommendations in reference to an advisory committee on executive compensation and on a staff appointment was postponed to the next Council meeting, on motion of Doctors Egan–Chojnacki, carried.

18. Honorary Membership

Doctor Picard said that the Douglas County Medical Society had granted honorary membership to retiring Dr. J. W. McGill of Superior, and asked that the Council do likewise.

On motion of Doctors Drew–Egan, carried, honorary membership in the State Medical Society was granted to Doctor McGill.

19. Report of Scientific Committee

Doctor Van Hecke reported that the committee had discussed and wished to report for information of the Council on two projects recommended by the advisory committee to the board of the Wisconsin Regional Medical Program which would be submitted for funding by the National Institutes of Health. One project would provide computerized information on treatment dosages for uterine cancer. The other would provide the latest treatment techniques and research discoveries by dialing a telephone number distributed only to medical personnel.

He said that the committee had also discussed, and reported for information, a news report on an automated clinic for detection of chronic diseases to be operated by a city health department, and patterned after the Kaiser Foundation health program. Computer results of tests, provided free to persons middle-aged and up, will be sent to the patient's private physician.

20. Fall Meeting of Council

On motion of Doctors Chojnacki–Hollenbeck, carried, the Council accepted the offer of Doctor Drew to make arrangements for a Council meeting at Dairymen's Country Club after Labor Day.

21. Further Report of Executive Committee

A. Division on Public Assistance

On motion of Doctors Egan–Schulz, carried, the Council approved the recommendation that this division be discontinued, with public assistance programs now under jurisdiction of the Commission on Medical Care Plans.

B. Rural Health

It was reported that the AMA Rural Health Conference will be held in Wisconsin in 1970, preferably in Milwaukee. On motion of Doctors J. H. Houghton–James, carried, the Council agreed that this subject falls within the jurisdiction of the Commission on Public Relations and Communications.

C. Woman's Auxiliary

It was reported that the Executive Committee met with officers of the Auxiliary in discussion and promotion of their activities, particularly in the area of health careers.

D. Drug Legislation and Dispensing Physicians

On motion of Doctors Chojnacki–Egan, carried, the Council approved recommended referral of this matter to the AMA delegation for report to the Council at the next meeting on any appropriate steps that might be taken.

E. Health Manpower

In view of studies and activities at various levels on the matter of health manpower, the committee recommended appointment of an ad hoc committee representing the Society, the State Board of Health and the State Board of Medical Examiners, to review the Medical Practice Act for possible amendments to relieve the situation. This recommendation was approved on motion of Doctors Egan–Chojnacki.

The committee reported further that it had received a report on Society insurance coverage; approved courtesy membership in the Section on Medical History for 50-year-club members and widows of physicians; referred to legal counsel for advice on county societies including meal charges in dues, and for review and later report on an administrative policy in the area of advising physicians with reference to hospital staff bylaws.

22. Adjournment

The meeting adjourned at 12 noon.

C. H. CROWNHART
Secretary

Approved:
JAMES C. FOX, M.D.
Chairman

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the wisconsin medical journal

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President's Message to the House of Delegates

By HAROLD J. KIEF, M.D., Fond du Lac, Wisconsin

State Medical Society: Aggressive Leadership in Action

BLUEPRINTS FOR TOMORROW

■ I AM SURE THAT the premise with which we can begin is that in this changing social order in which we are now embroiled, the definition of adequate health care has changed considerably. Adequate health care for all Americans has been moved from the realm of a debatable social issue to a position of public policy. Perfect health is now a governmental right! Medicare has come to stay and any further discussion in this regard will probably be limited to correcting the obvious operational problems and expanding its scope to include certain additional groups. The real importance has been that government is now in the business of providing for medical care to a sizable segment of the country's population and, because of this, government has a direct interest in the adequacy of health care costs of the facilities, and the personnel needed in order to provide this adequate medical care.

Most areas of our medical economy—the commercial insurance industry, the Blue Plans, and the Hospital Association—know that they are in a time of transition; that we are living in an age of shifting social, economic, and political realities which envelop all who are concerned with health care be they providers, consumers, or insurers.

Doctors have, for the most part, been too busy in their everyday practice to stop even long enough to be aware of this impending state of change, much less take off time enough to provide solutions to the problems we face. Most often the profession is engaged in an action to secure or try and retrieve what we think is ours. We are attempting to keep alive the basic ideal of practice when we should realize that these ideals should be reviewed and looked at during these changing times by us, the profession, rather than by public opinion propagandized by a bureaucratic government.

In the future, we must go from a battle whose dust is settling, or should be settled, to long-range testings of new values and new goals. It is at this time, in this year and in the few short years to come that we, the profession, must be the planners, the surveyors, and the initiators. I am sure that all the physicians in this room and within

Presented before the House of Delegates at the 126th Annual Meeting of the State Medical Society, May 8, 1967, Milwaukee.

our state realize that the poor and unfortunate, and the ill in our society must be aided, and in accordance with the American tradition generously so, both by private and public means. And, in doing so we believe that there is no need to force the entire population of our country into an ever-expanding web of compulsory governmental welfare programs for everyone. Yes, this we believe, but this isn't what is happening, merely because we have not seen sufficient action.

The choice open today to the medical profession is no longer whether there will be changes, the choice is only to decide whether they want to have a part in directing these changes and effecting them in ways that we, as doctors, consider them as to their impact on the medical care provided. But we must always remember, doctors, that if we guide and initiate, we do this not merely because government says so, but because we are members of a learned and sensitively human profession. Where must we begin to plan and initiate? We must begin with united effort in every locality, in every city, in every county. The State Medical Society of Wisconsin has the aggressive leadership. It is 4,800 strong and this is the year to implement this leadership.

Organized medicine, of which you are an integral part, must also take a more active role in the national planning stages of this changing social era, this environment that we now live in but did not dream about 20 and 30 years ago. We are all aware that the population is growing at a pace that is not matched by our production of doctors, nurses, and paramedical personnel. Hospital and nursing home beds are at a premium with the ever-mounting demands for adequate medical care. Costs with all the newer facilities required for this adequate modern day care are rising rapidly to levels that may become critical in themselves. The people will demand, and the politicians will campaign that something be done.

Government, being in the business, will feel the responsibility and will promote its own solutions and something will be done!

But let us, the medical profession, lend our humanism, our feelings for our patients, yes, our duties as a citizen to a greater effort to become aware of our medical problems and to plan, survey, and initiate solutions. What do we see in the future probable solution? How can we as doctors solve these problems?

Consider for a moment some of these aspects: Since the discontinuance of internships in the community hospital, we have graduated doctors trained and oriented only in the large medical center type practice. It is no wonder we have many communities without doctors and many more where their only doctor is soon to leave and never to be replaced. The present day medical school graduate will not, and probably could or should not, practice alone in a small community without the diverse facilities and consultations of the modern medical center. This alone is a major factor to which we must adjust our concepts for the future.

Furthermore, medical education, in order to attract young men interested in becoming doctors, might streamline the basic use of study and make it feasible, both time-wise and money-wise, for a young man to gain his M.D. degree. Might we not consider starting medical courses along with the required liberal arts studies immediately upon graduation from high school and integrate these studies to about a six-year course. Maybe we should give a certificate of graduation at this stage, provide residency-type training for an additional three years and then issue an M.D. degree and license to practice. Possibly we could even consider issuance of a limited license according to specialty training. The point is, medical education must change its methods.

Graduate medical training is changing its methods. It is no accident that government is studying right now the subject of post-graduate medical training and establishing centers about the country in the concern over heart-cancer-stroke. None of us, I am sure, are naive enough to believe that this is where these subjects are intended to end. Doctor Hirschboeck, the Director of the Regional Medical Care Program in Wisconsin, will be the first to tell you, "Yes, this program will not encompass these three categories of illness alone, but will eventually encompass most of the field of medicine." We must see to it that these plans and that the format and final answers will be under our direction.

But the Regional Medical Care Program is but the forerunner. We will probably have medical centers throughout the land serving communities, augmenting and becoming an

integral part of the educational system of medicine and the training of auxiliary medical personnel, and you and I will be part of this way of practicing medicine.

In 1967, the State Board of Health will implement the Comprehensive Planning Act of November 1966, as directed by Congress. This will be a monumental study planning to provide adequate medical care for every individual in the state of Wisconsin whether they are in rural areas, urban areas, or in core areas. For these tasks we need manpower. This manpower must come from the enthusiasm, from the working ability of doctors of the State Medical Society of Wisconsin.

In our computerized civilization, medicine itself has become highly sophisticated. It would appear that it is no longer possible for the individual practitioner, or even the small group, to provide many of the requirements of quality care as we know it today. One of the most compelling forces behind it all is the requirement to make the most efficient use possible of the limited number of medical personnel available and this may mean collecting these talents into medical centers or areas.

Here, with computers, x-ray departments, scanning equipment, isotopes, intensive care centers, burn centers, and blood banks, you may be practicing according to your education and training. These centers probably, in the future, will be subsidized in order to provide this comprehensive type care and the smaller communities and rural areas surrounding such a center undoubtedly will be serviced by helicopter ambulance, as well as the usual road facilities.

I am sure that in the future outpatient diagnostic care and treatment will be authorized by all types of insurance and governmental payments in order to preserve hospital beds for treatment of very ill patients. I can envision overnight motel type accommodations provided for the clinic outpatient having to come quite a distance.

Another method of attack on the problem of personnel might be one large electronically equipped laboratory in an area, a laboratory jointly owned and supervised by participating physicians to help relieve the personnel shortage.

We must investigate methods of time studies for our daily work load. It is possible to inquire as to what part of tasks with patients might well be left to a well-trained social worker whom "we" hire. Might not an increased use of surgical technicians free a second doctor so that more patients could be seen. It is possible we can develop the physician-assistants as the "Felschar" system of Russia.

However, in planning or initiating any new methods, we, the State Medical Society of Wisconsin, must help to expand a public relations program to explain to the public about any new methods and, therefore, by enlightening the public, gain their support.

Yes, one could go on and on, explaining in more detail, this look into the future, but my purpose here is only to awaken you to the problem that we as doctors face. Medicine needs your help more today than at any time in the past. We must take an active part in doing everything in our power to preserve what is good and to lend our talents to see that the blueprints for tomorrow contain something of the American way. This is why SMS must mean to all of us aggressive leadership in action. And as we gird to action, I know that our doctors will do this with but one thought, and that is—better health care for the citizens of Wisconsin.

In closing, I wish to quote from a verse that summarizes what I mean.

"Though men may justly praise for work well done,
With science burgeoning and spreading far,
This swift enlargement of creative flow,
The need has grown. Scan well the sky, for lo!
Above that placid lake there shines a star,
'More perfect health' is still your goal, march on!"

Dollars Today—
—Doctors Tomorrow

American Medical Association
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AMA-ERF

CASE REPORT

Hypercortisonism, Moniliasis and Arthritis

By MILTON C. BORMAN, M.D. and ROBERT B. PITTELKOW, M.D., Milwaukee, Wisconsin

■ THIS REPORT CONCERNS a case in which there is a suggestive relationship between excessive dosage of corticosteroids and the onset of both cutaneous moniliasis and arthritis of a rheumatoid type.

CASE REPORT

A 34-year-old married white woman, mother of three healthy children, was admitted to the hospital in April 1961, complaining of severe joint pains, diffuse scaly skin lesions, and excessive weight gain. She recounted that when she was shopping for a Christmas tree the previous December, she sustained a moderately severe frostbitten right third finger. The numb and waxy-white finger regained color when she returned home but continued to be swollen and tender. A physician prescribed six 5 mg tablets of prednisone (Meticorten) daily for 3 days. There being no improvement, the dosage was doubled. By Christmas day the ankles and feet had become swollen and painful, and three weeks later she was admitted to a hospital after being in bed at home for a week. At this time there was a diffuse scaling eruption on the scalp, which spread rapidly to the other hairy areas, the extremities, and buttocks. There was no pruritis. She was treated for 30 days, first in the hospital and then at home, with fungicidal agents (exact nature not known) and prednisone, 50 mg daily. There was no improvement. In mid-March prednisone therapy was discontinued and 5 tablets of 0.75 mg of dexamethasone (Decadron) daily was substituted. At this time the patient had gained 24 lb in weight and complained of shortness of breath and chest pain unrelieved by diuretics.

When admitted to our hospital in late April 1961, the patient was 5 ft 5 in tall and weighed 165 lb. She had a typical Cushingoid appearance, was having severe joint pains, was scarcely able to walk, and was greatly depressed. The ankles, knees, proximal interphalangeal joint of the right third finger, the left second toe, left elbow, and both temporomandibular joints were swollen, hot, and tender. The scalp and other hairy portions of the body, the extremities, trunk, and intertrigenous areas were covered with a generalized exfoliative erythroderma with many moist, red patches (Fig 1). The membranes of the mouth and vagina were fiery red. The peripheral halves of the fingernails were a dirty grayish-yellow color with thick debris beneath them. The soles of the feet were cold and moist. Her temperature was 99.4 F, blood pressure 118/80 mm Hg, heart rate 94 beats per minute. The family, and her own history were not contributory except as noted above. She smoked one package of cigarettes daily and did not consume alcohol.

Laboratory Findings. Upon admission the urine was negative for sugar and albumin; specific gravity, 1.008 and 1.013; occasional red and white blood cells. The blood urea nitrogen was 10 mg per 100 ml; total protein 5.98 gm per 100 ml, albumin-globulin ratio 2.94/3.04. Fasting blood sugar was 78 mg per 100 ml; serum chlorides, sodium, potassium, calcium, and phosphorus contents were within normal limits. Hemoglobin level was 12.6 gm per 100 ml; white blood cell count 14,350 per cu mm (differential count: segmented neutrophils, 49; nonsegmented neutrophils, 19; lymphocytes, 22; monocytes, 8; eosinophils, 2); and there were toxic

Fig. 1—Exfoliative erythroderma of soles.

From the Departments of Medicine (Doctor Borman) and Dermatology (Doctor Pittelkow) of Columbia Hospital.

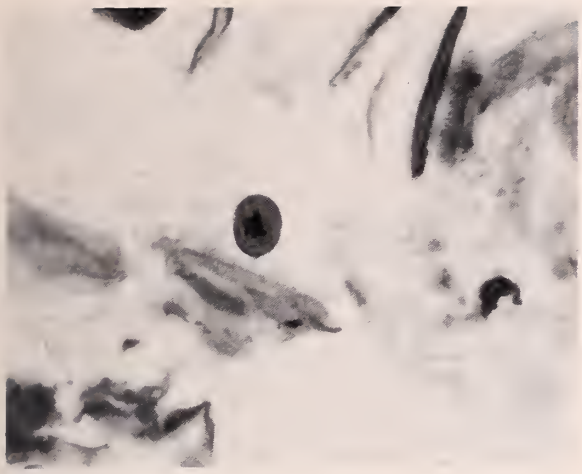

Fig. 2—Spores within crusted material of epidermis.

granulations in the polymorphonuclear cells; there were 249,000 platelets per cu mm.

The erythrocyte sedimentation rate was 54.0 upon admission and 79.8 and 87.0 upon subsequent occasions. The test for syphilis was negative, C-reaction protein 2 ml, uric acid 5.5 mg per 100 ml. Feces examination was positive for occult blood. The latex test for rheumatoid factor was negative and so were three successive LE preparation smears. Specimens taken from the hands, feet, chest, and vagina revealed heavy growth of *Candida albicans*. Biopsy of a scaling area on the left upper arm disclosed, in both Gram- and PAS-stained sections, budding yeast-like spores within the hyperkeratotic and parakeratotic crusted material of the epidermal surface but not within the viable epidermal or dermal tissues; significant numbers of bacteria were not present (Fig 2).

X-ray Findings. Examination of the hands and fingers revealed periarticular enlargement, particularly of the middle finger of the right hand; there was some bone atrophy of this hand but no actual destruction or spurring. Osteoporotic changes were seen about all joints of both hands, as well as some decrease in the joint spaces, especially in the proximal interphalangeal. There appeared to be some soft tissue swelling also, especially about the right middle finger, and there was questionable cortical erosion of this joint. The metatarsophalangeal and interphalangeal joints of both feet showed, to a slightly lesser degree, the same changes seen in the hands. The lumbar spine, pelvis, hip, sacroiliac, knee and ankle joints were normal except for minimal osteoporotic changes about the ankles. The general condition of the teeth was good; there were no apical abscesses but some alveolar absorption about the neighboring teeth of several edentulous areas was seen.

Treatment. Up to time of the April admission, the patient had taken 4,000 mg of prednisone in 81 days and 162 mg of dexamethasone in 43 days. Immediately gradual withdrawal of this therapy was begun, with completion in 10 days without untoward incidents. Gold injections were begun but discontinued when an erythematous eruption appeared on the thighs after 3 weeks, the calculated gold residue being 56 mg at this time. Prochlorperazine (Compazine), 10 mg daily, ascorbic acid 500 mg three times daily, and aspirin were prescribed. Improvement was steady, and she was discharged with the skin cleared a month after admission. She was asked to continue 3.0 gm (50 gr) of aspirin daily, 10 hours bed rest, a daily hot tub, 10 minutes of sunshine daily when possible, and postural and deep-breathing exercises.

Subsequent Course. In the five years following hospital discharge, the patient has had several recurrences of the arthritis in the following joints: terminal interphalangeal of two fingers and proximal interphalangeal of one; the left wrist; the metatarsophalangeal joints of the toes, both knees, the cervical spine, left elbow, left shoulder; the metacarpophalangeal joints of the right and left third finger. Under gold therapy, resumed at the time of the first recurrence, the episodes have been of short duration and controlled satisfactorily for the patient, who is more concerned about the skin than about the joint lesions. At present (June 1966) the calculated gold residue is 1,013 mg.

The monilial recurrences have involved the buttocks, perineum, nails of two fingers and two toes; two badly deformed toenails have been removed, at which time the laboratory reported "localized inflammation showing infiltration with polymorphonuclear leukocytes; fungal stain showed scattered group of hyphae in various parts of both nails." For the worst recurrence the patient was re-hospitalized in May 1966, for intensive dermatologic therapy. The response to topical corticosteroids and ultraviolet therapy was very good.

DISCUSSION

In a review of candidal endocarditis in 1960 Pearl and Sidansky[1] included one case, without details, in which the underlying malady had been rheumatoid arthritis. Furthermore, there was also the suggestion in one of their own two cases that corticosteroid treatment of a preceding debilitating illness may have been provocative of the candidal infection. Then, in 1962, Gardner and associates[2] reported two cases of rheumatoid arthritis in which death resulted from fungus disease. In the first, Candida endocarditis complicated prolonged corticosteroid therapy; in the second, systemic nocardiosis resulted in the formation of mycotic lung and cerebral abscesses and in nocardial arthritis. On the basis of these cases, the tentative suggestion was advanced that certain of the granulomas in rheumatoid arthritis may be of mycotic origin.

In our own case we cannot consider the evidence to be in firm support of Gardner's surmise for the reason that the absence of rheumatic nodules, of a hypochromic-microcytic anemia and of a positive latex test, coupled with the reversed albumin-globulin ratio confuse the diagnosis of rheumatoid arthritis. On the other hand, the x-ray findings in the involved joints do resemble closely those of rheumatoid arthritis. The coupling of the skin lesions with the arthritis suggests that the latter may be of the "psoriasis" type, but this diagnosis is not by any means unanimously accepted by rheumatologists and dermatologists. So far as the fungus infection is concerned, it may be said that the species of Candida can be isolated from the skin and mucous membranes of healthy persons so often that the significance of a single positive culture is frequently difficult to determine. If, however, the organism is consistently isolated from many different sites simultaneously, a diagnosis of candidiosis is warranted. Our case certainly fulfilled these criteria.

SUMMARY

A case is reported in which there is suggestive evidence that excessive use of corticosteroids may have precipitated the onset of both rheumatoid arthritis and dermatologic and vaginal candidiosis.

(M.C.B.) 324 E. Wisconsin Ave. (53202).

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MULTIPLE PARATHYROID ADENOMAS

WALTER D. SCHWINDT, M.D., Department of Surgery, University of Wisconsin Medical School, Madison: *JAMA* 199:945–946 (Mar 20) 1967.

When more than one enlarged parathyroid gland is found in a patient with hyperparathyroidism, it has been suggested that hyperplasia rather than multiple adenomas may be the etiology of the hyperparathyroidism. A case is presented of a thirty-seven year old housewife who had the onset of acute abdominal pain which subsequently proved to be a perforated duodenal ulcer complicated by a subphrenic abscess. In the course of our examination, it was found that she had gastric hypersecretion in addition to hyperparathyroidism.

The initial surgical procedure consisted of draining the subphrenic abscess. Following this procedure, a cervical exploration was performed at which time three enlarged parathyroid glands were identified. The fourth parathyroid was identified, which appeared normal in size, and a biopsy of this small gland was interpreted as showing normal parathyroid tissue. The other three glands were then excised and on examination showed a mixed cellular type, however, the water-clear cell was most predominant. In addition there was compressed normal parathyroid gland along the edge of each of these adenomas.

Postoperatively the patient did well without signs of hypocalcemia and complete resolution of her ulcer complaints. This case demonstrates the need to find all the parathyroids during surgery, since one might have assumed that hyperplasia rather than adenomas was present. In addition, it also demonstrates that a portion of a normal parathyroid gland is capable of adequate calcium metabolism.

AAP PUBLISHES MANUAL ON CHILD ADOPTION

The American Academy of Pediatrics recently released a comprehensive study dealing with all facets of the adoptive process. Entitled *Adoption of Children*, the manual provides in-depth information about a subject of primary importance to pediatricians, as well as attorneys, social workers, and other physicians.

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Copies of the book may be obtained from the AAP for $1.50 per copy. Address: Department of Public Information, 1801 Hinman Ave., Evanston, Ill. 60204.

Intra-oral Presentation of Lateral Pharyngeal Space Tumors

CASE REPORT

By DOUGLAS D. HARRIS, M.D., Madison, Wisconsin

■ THE PAROTID GLAND lies in such a position that 80% to 85% of the total gland is superficial to the ascending ramus of the mandible and the remaining portion is in the retromandibular or lateral pharyngeal space. Tumors which arise from the retromandibular portion of the parotid gland in the lateral pharyngeal space present different problems than those of the superficial lobe.

CASE REPORT

A 76-year-old white woman was admitted to the hospital. Seven months prior to admission during a routine examination, a large mass was noted in the left lateral pharyngeal area. This was described as being slightly inflammed and a diagnosis of peritonsillar abscess was made. Penicillin was given without regression of the mass. The patient was then referred to an otolaryngologist who incised it but did not obtain purulent exudate. The patient was then sent to this hospital. The patient stated that she had a sensation of fullness or "something in the throat" but experienced no pain. She had some generalized symptoms of weakness.

Physical examination showed smooth mucosa without evidence of ulceration in the left lateral pharynx. A 6x7-cm mass was noted as being ballotteable by bimanual palpation in the lateral left pharynx. The impression was a solid tumor, either a reticulum cell sarcoma or lymphosarcoma of salivary gland origin. A deep lobe of the parotid tumor had to be excluded. A biopsy was taken through the overlying oral pharyngeal mucosa and showed mixed salivary gland tumor, benign. The patient had several medical problems which necessitated further investigation prior to definitive therapy for the lateral pharyngeal tumor. She had hypochromic microcytic anemia and hypertension for which she received treatment.

Two weeks after admission the patient was operated upon, using an external approach through a routine parotidectomy incision. The facial nerve was carefully isolated at the onset of the procedure (Fig 1). It was noted to be displaced inferiorly by the massive tumor which extended behind the ramus of the mandible. The facial nerve was carefully dissected out and the tumor was freed from its compartment by resecting the styloid process and allowing the stylopharyngeus, styloglossus, and stylohyoid muscles to be retracted inferiorly. The mandible was retracted anteriorly and the tumor was removed from the lateral pharyngeal space by downward and anterior displacement (Fig 2). During the course of removal of the tumor, the capsule was ruptured because of its large size. The tumor was felt, at the completion of the operation, to be completely enucleated (Fig 3). The space was thor-

Fig. 1—The facial nerve trunk is pointed out by the hemostats. The tumor mass lies beneath the facial nerve.

From the Department of Otolaryngology, University of Wisconsin Hospitals.

Fig. 2—The space occupied by the tumor is seen in the center medial to the facial nerve. The ear is retracted in upper right.

Fig. 3—Contents on sectioning tumor. Benign mixed tumor of deep lobe parotid.

oughly irrigated with distilled water and a large drain was then placed.

The histopathologic report of this specimen was a benign mixed salivary gland tumor (Fig 4). The superficial lobe of the parotid was not involved. The facial nerve showed no evidence of damage postoperatively and there was no evidence of involvement at the base of the skull or its surrounding tissues. Her convalescence was uneventful and the patient was dismissed symptom-free six days postoperatively. The patient, at the time of her six-month follow-up examination, is asymptomatic and the pharynx appears normal.

DISCUSSION

ANATOMICAL CONSIDERATIONS. The lateral pharyngeal space has the following anatomical boundaries: The lateral wall of the deep lobe of the parotid contains the facial nerve posteriorly and the ramus of the mandible with pterygoid muscles attached anteriorly. The medial wall is the superior constrictor muscle and fascia extending from the median raphe to the base of the sphenoid and anteriorly to the anterior tonsillar pillar. The inferior boundary is the stylomandibular diaphragm and ligament. This is a fascia sheath containing the stylohyoid, stylopharyngeus, and styloglossus muscles, extending from the styloid process to the anterior pillar of the tonsil. The superior boundary is the base of the skull. Anatomically, the deep lobe of the parotid is surrounded by bony or rigid structures on three sides. Thus, expansion of a tumor in this area is into the soft lateral pharynx giving rise to pharyngeal symptoms.

SYMPTOMS. A report of 12 cases by Morfit[1] presents the typical complaints of patient with lateral pharyngeal space tumors. Two cases presented with a lump in the throat for greater than four years; one case presented with difficulty in swallowing for about eight months; and another case presented with a pressure or sensation of something caught in the throat for a period of six months. Three cases were asymptomatic and found as part of a routine physical examination. Beahrs[2] reviewed 760 cases of parotid tumors and also noted the similar pharyngeal symptoms in the deep lobe tumors.

INCIDENCE. Deep lobe parotid tumors have been reported in patients from 6 to 76 years of age. Sex incidence shows 60% occurring in females.

COURSE. The clinical course of the tumor as it arises is regulated by its anatomical position. The hard bony barrier of the ramus of the mandible prevents any lateral expansion of the tumor as does the bony barrier of the skull superiorly and posteriorly. Thus, there is no evidence of growth of the tumor externally unless the superficial lobe is also involved. Usually, even in the advanced stages, there is no ulceration of the oral mucosa in the lateral pharyngeal wall or tonsillar area. The mass can be detected by enlargement of the area and by ballottement examination intra-orally and externally.

In the cases reported by Morfit,[1] there were no findings in the clinical examination that would suggest the tumor was benign or malignant preoperatively. The malignant tumors encountered in this series were firmly affixed and had infiltrated into the base of the skull; there was no pain or paralysis noted. The first evidence of a malignant tumor was at the time of surgery.

DIFFERENTIAL DIAGNOSIS. Masses presenting intra-orally that would simulate deep lobe of the parotid tumors must be considered in the differential diagnosis as follows:

1. *Superficial tumors:* The majority of intra-oral neoplasms arise in the mucosa of the oral cavity or in the pharynx and present early as surface lesions.
2. *Minor salivary gland tumors:* The histological picture of the minor salivary glands would be similar to those of the major salivary glands. The only difference would be in the clinical examination showing the particular anatomical site of origin. The retromandibular tumor presents as a bulge in the posterior lateral pharyngeal wall, whereas the minor salivary glands are indiscriminate in their location in the oral cavity.
3. *Lymphosarcoma:* These tumors primarily arise in the tonsil and lymphoid tissue of Waldeyer's Ring, but are usually clearly identified as arising superficially in the pharynx and can be differentiated from an underlying lateral pharyngeal distortion.

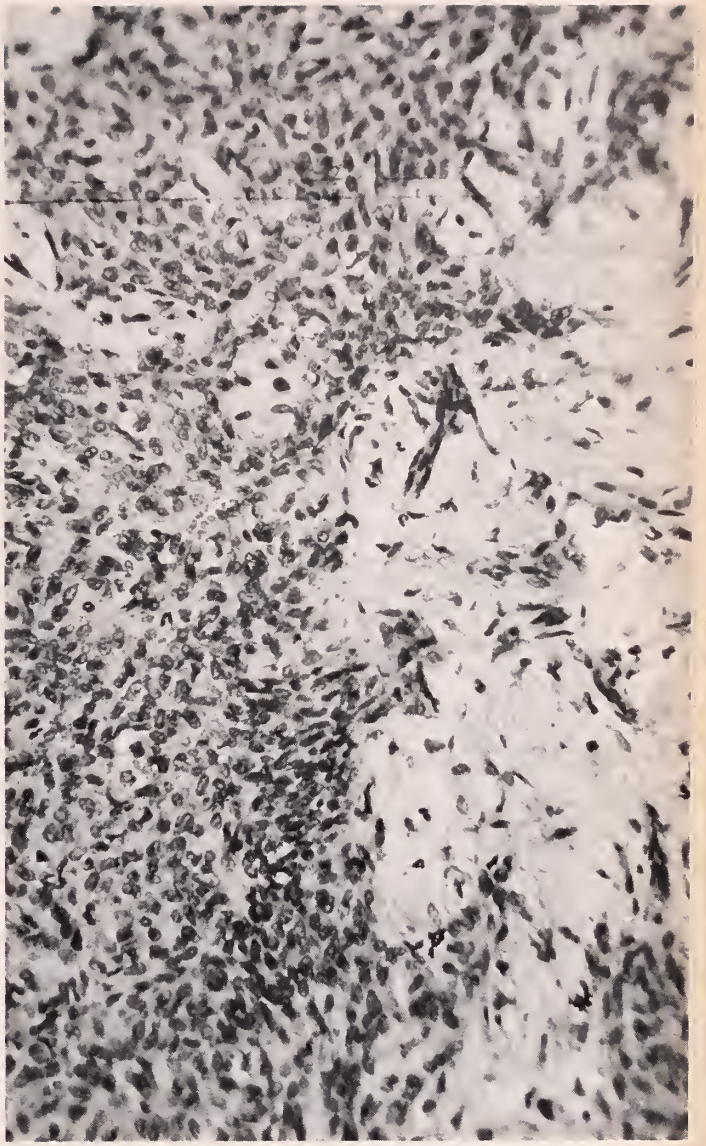

Fig. 4—High-power microscopic view of mixed tumor of parotid.

4. *Retropharyngeal abscesses:* These can be distinguished by the associated pain and toxic course of the patient clinically, plus their tenderness to palpation and inability to ballotte.
5. *Tumors of the parotid gland:* Deep portion. Seventy-nine per cent of these tumors are benign with mixed tumor the most common.[2]
6. *Aneursyms of the internal carotid artery:* These will occasionally present as a bulge in the lateral pharyngeal wall. They usually are pulsating and can readily be recognized.

7. *Carotid body tumors:* These ordinarily present with a tumor mass also present in the neck.
8. *Chordomas:* These lesions characteristically arise in the mid-portion and produce their distortion in the posterior pharyngeal wall rather than the lateral wall.
9. *Leiomyoma:* Work[3] reported one case which presented as a lateral pharyngeal space mass.

DIAGNOSIS. The diagnosis of deep lobe parotid tumors should be suspected when the clinical examination reveals a mass in the lateral pharyngeal space which is firm to palpation. It may be palpated by placing the fingers over the mass intra-orally and with the other hand ballotting externally medial to the angle of the mandible and anterior to the sternocleidomastoid. The size of the tumor may also be estimated by this procedure. The definitive diagnosis is made by biopsy.

SURGICAL REMOVAL. The surgical exposure of the deep lobe of the parotid is an important facet in the management of these tumors. The vital structures of the retrostyloid area consist of the carotid artery, internal jugular vein, and the cranial nerves IX, X, XI, and XII as they exit from the skull. These structures lying directly behind the deep lobe demand an external approach with proper exposure.

The patient's head is extended and turned to better expose the lesion. The head is draped so that the intra-oral palpation to manipulate the tumor during the procedure may be done. A parotidectomy incision in a Y fashion is performed extending the inferior incision approximately 8 cm along the anterior border of the sternocleidomastoid. The facial nerve is exposed. The nerve may be displaced inferiorly by the mass of the tumor. It should not be necessary to cut any of the branches of the facial nerve. The tumor is dissected from the medial surface of the nerve and the styloid process is palpated anterior to the mastoid tip. The stylomandibular ligament will be restricting the inferior dislocation of the tumor. The styloid process is resected. The tumor, then by blunt and sharp dissection with help by intra-oral manipulation if necessary, is enucleated from its bed. The tumor is delivered inferiorly and anteriorly under the mandible.

If the histologic diagnosis is a benign tumor, a deep drain may be placed in the lateral pharyngeal space and the wound closed. If the tissue diagnosis is a malignant tumor, a superficial lobectomy of the parotid is performed. The facial nerve is preserved if possible. A radical neck dissection may be included as an elective procedure.

The postoperative course for benign tumor removal should be uncomplicated, giving fluids orally the first day and normal diet thereafter. The morbidity is minimal.

PROGNOSIS. Adequate excision of benign tumors of the lateral pharyngeal space generally eliminates the disease. However, benign mixed tumors of the deep lobe do recur despite adequate excision.[3] From a group of 11 cases reported by Work,[3] one case showed recurrence in 5 years, another in 28 years.

Total removal of malignant disease in this area is difficult and holds a guarded prognosis.

SUMMARY

A case of a benign mixed tumor of the deep lobe of the parotid gland is presented. The anatomical review of tumors in the lateral pharyngeal space, the presenting symptoms, differential diagnosis, clinical course, and management are discussed.

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Selective Percutaneous Arterial Catheterization

By GEORGE W. WIRTANEN, M.D., Madison, Wisconsin

■ THE PERCUTANEOUS APPROACH to arterial catherization was first introduced in 1951 by Peirce[1] who threaded a catheter through a needle which had been inserted percutaneously into the femoral artery. This technique was refined in 1953 by Seldinger[2] who employed a catheter exchange technique which is the presently employed percutaneous method. The catheter exchange technique involves percutaneous puncture of the artery, insertion of a flexible tipped wire guide through the needle into the arterial lumen, removal of the needle and placement of a catheter over the wire guide into the arterial lumen with removal of the wire guide, so that only the catheter remains intra-arterial.

The Radiotherapy Center at University Hospitals was opened in December 1963, and was built and equipped with funds from the National Institutes of Health, American Cancer Society, Wisconsin Alumni Research Foundation, and other agencies, to better cope with the therapeutic and diagnostic radiologic aspects of malignant disease. Equipment includes nine-inch image intensification with stereo-cine and direct and television viewing, video and audio tape recording, bi-plane film changer, automatic contrast injector, a peripheral angiography unit, and conventional and transverse tomography. These facilities made it possible to introduce the present program of selective percutaneous arterial catheterization.

METHODS AND MATERIALS

To date, 230 catheterizations have been performed, 97% of which have been for the placement of indwelling intra-arterial catheters for continuous chemotherapeutic infusions, in both primary and secondary carcinoma. Diagnostic, nonchemotherapeutic arteriography has been of two types. Celiac axis arteriography has been used in an attempt to diagnose pancreatic carcinoma, and bilateral internal iliac arteriography combined with intra- and perivesical oxygen has been used in an attempt to stage bladder carcinoma. Continuous intra-arterial tumor chemotherapy has been carried out by the Division of Clinical Oncology under the direction of Dr. A. R. Curreri and Dr. F. J. Ansfield with patients receiving chemotherapy alone or chemotherapy in combination with radiotherapy which is administered either concomitantly or sequentially. It is the purpose here to emphasize the catheterization and arteriographic aspects rather than to present an analysis of the radio- and chemotherapeutic results.

Three basic percutaneous sites are used: The transcarotid for selective internal or external carotid artery catheterization, the transbrachial for internal mammary (Fig 1), celiac axis, gastroduodenal (Fig 2), renal, right, left, and common hepatic (Fig 3), and internal iliac artery catheterization (Fig 4), and the transfemoral approach for bronchial (Fig 5), carotid, celiac axis, renal, common iliac, external iliac, and internal iliac artery catheterization (Fig 6).

General anesthesia has been used in four patients because of severe pain when lying supine. The remainder of the patients have been given a sedative prior to the procedure, with the percutaneous site infiltrated with a local anesthetic, arterial puncture performed, and catheter exchange technique carried out. Catheters employed are cold-sterilized, preformed, nonradiopaque polyethylene having external diameters of either .067 or .082 inches. These intra-arterial catheters are filled with contrast material, so that visualization with image intensification and television monitoring is possible. Selective catheterization is then carried out, arteriography

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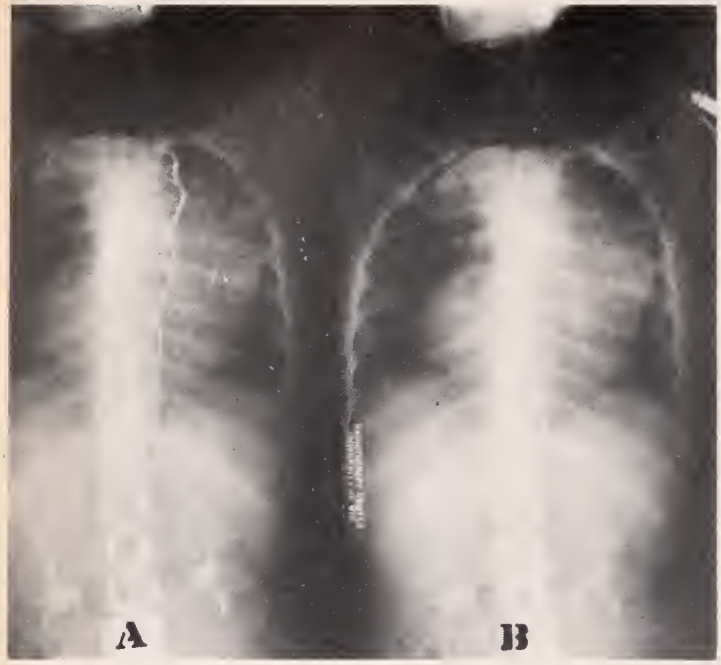

Fig. 1—(A) Arterial phase of contrast material filling the left internal mammary artery which supplies branches to a mediastinal tumor. (B) Venous phase demonstrating pooling of contrast in the mass lesion. The patient received post-infusion radiotherapy.

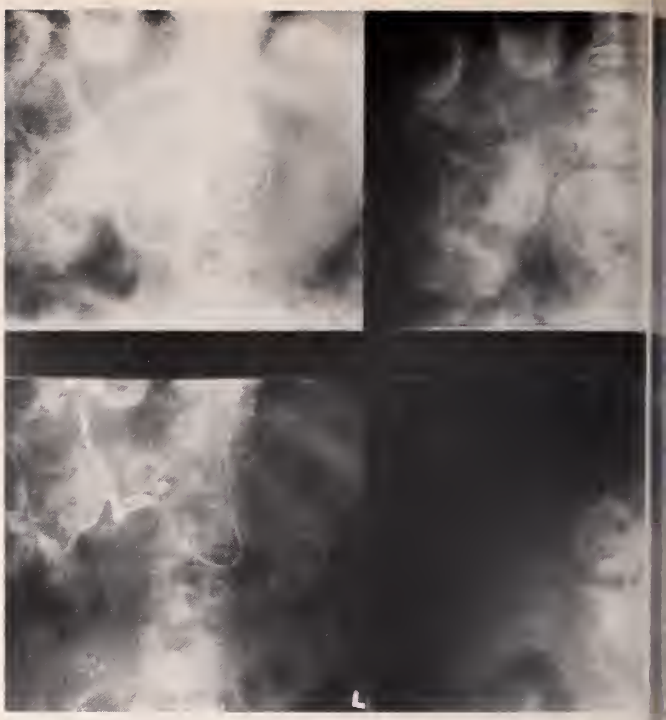

Fig. 3—Patient with large vascular metastases from carcinoma of the stomach. (Top left) Transbrachial common hepatic artery arteriogram. (Top right) Venous phase of same arteriogram demonstrating persistent contrast in the metastases. (Bottom left) Selective right hepatic artery catheterization. (Bottom right) Selective left hepatic artery catheterization (residual barium is also present in the stomach).

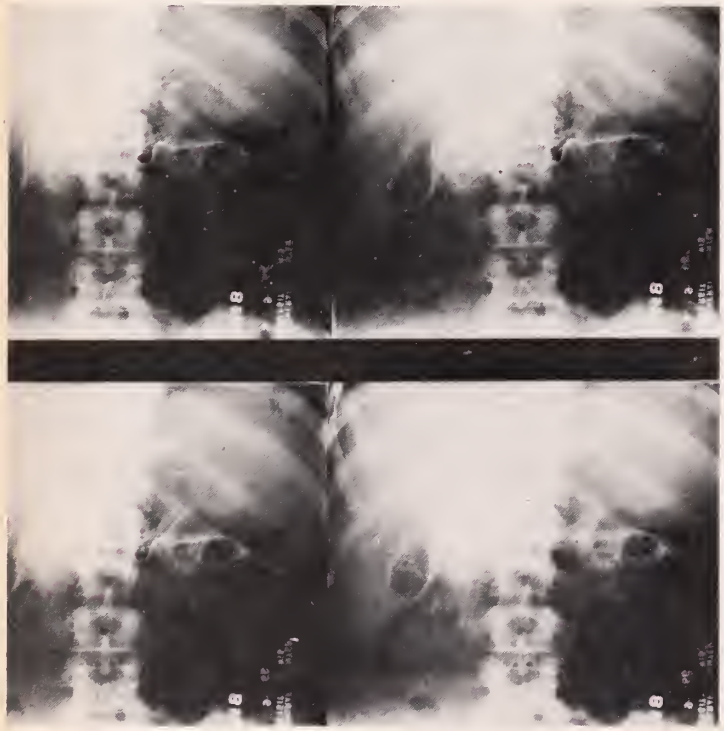

Fig. 2—Percutaneous brachial artery approach to the gastroduodenal artery demonstrating contrast accumulation in the head of the pancreas with excellent visualization of the transverse pancreatic artery. The patient received continuous intra-arterial infusion followed by radiotherapy for carcinoma of the head of the pancreas.

Fig. 4—Patient with metastatic carcinoma of the penis to the right pelvis and inguinal nodes. Left transbrachial artery catheterization of right internal iliac artery for chemotherapeutic infusion. Arteriogram demonstrates tumor vascularity in the pelvis with the bladder displaced into the left pelvis. Residual nodal contrast material is present from previous lymphography.

Fig. 5—Indwelling intercosto-bronchial artery catheter which remained in place 19 days employing a right transfemoral approach demonstrating the tumor blood supply to a bronchogenic carcinoma via the right upper lobe bronchial artery. The patient received post-infusion radiotherapy.

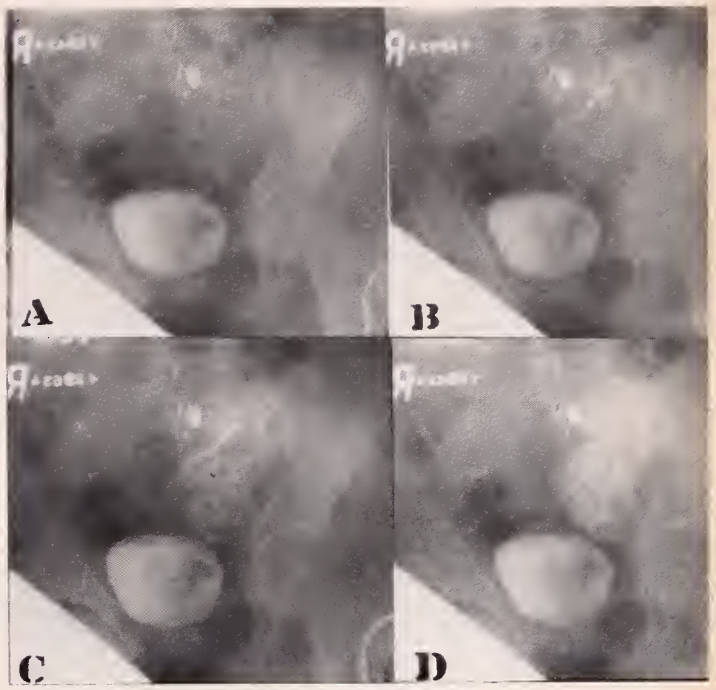

Fig. 6—Left transfemoral approach to infuse a large intrapelvic metastasis from an osteogenic sarcoma. Contrast material is present in the bladder with the tumor stain seen best in D overlying the left sacrum, superior to the bladder, adjacent to the small lytic metastatic focus in the left ilium. The patient received post-infusion radiotherapy.

performed, and if patients are to receive chemotherapeutic infusion intra-arterially, a pressure infuser system is attached to the catheter for long-term chemotherapeutic infusion.

RESULTS

Patient tolerance of indwelling catheters has been reasonably good and patients with transbrachial intrahepatic artery catheters have received chemotherapy as outpatients, several have returned to work with catheters in place and catheterization has been carried out even on an outpatient basis. The polyethylene catheters have remained in place for varying periods of time up to 62 days. Recatheterization has been possible with catheters being placed for as many as four separate courses of chemotherapeutic infusion.

Arteriograms with a rapid film changer assure that the catheter is situated in such fashion that the chemotherapy will in fact, infuse the tumor. It also allows an evaluation of tumor vascularity or avascularity and when done serially as before therapy and after therapy, reveals whether any objective changes have occurred from the form of therapy employed.

Unsuccessful placement of indwelling arterial catheters occurred in 13 patients, in 9 of whom we were unable to place a bronchial or intercostobronchial artery catheter, in 3 patients in whom we were unable to selectively catheterize the vessels because of technical difficulties, and in one patient in whom we were unable to pass the catheter retrograde through the iliac arteries because of severe vessel tortuosity. This technique has not produced acute arterial occlusion requiring surgical intervention. Surgical intervention, however, has been required in 3 patients because of bacterial infection developing along the catheter tract from the percutaneous site to the arterial puncture site during long-term infusion. Extra-arterial guide wire fracture occurred in one patient, and 2 patients developed peripheral septic emboli distal to the arteriotomy site.

SUMMARY

Selective percutaneous arterial catheterization has been carried out with the catheter exchange technique since 1953. This method has been employed at University Hospitals

since 1964 and in the Radiotherapy Center has been used for the placement of indwelling intra-arterial catheters for continuous chemotherapeutic infusion and in the diagnosis of malignant disease. Long-term infusion is possible with this technique and arteriography allows one to fully appreciate the extent of neoplastic involvement. Catheters are reasonably well tolerated by patients, but the procedure has a small, though definite, morbidity.

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Presented by the Wisconsin Society of Pathologists
S. L. Inhorn, M.D., Madison, Chairman of the Publications Committee

Arthropod-Borne California Group Viral Encephalitis in Wisconsin

By WAYNE H. THOMPSON, D.V.M., M.P.H., Ph.D.
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■ FIRST EVIDENCE of widespread human infection with California-group arbovirus in an area of the United States other than California was found in 1962, during a serologic survey for evidence of past infections with arboviruses in Wisconsin residents.[1] Twenty-four per cent of sera from 637 outdoor workers had neutralizing antibodies against California virus, indicating past infection with the virus. California was by far the most common arbovirus antibody found; in comparison, only 4% had neutralizing antibodies to St. Louis, 1% to western, and none to eastern encephalitis virus. Most of those who had antibodies to California virus lived in rural areas of the state, where there were relatively frequent opportunities for exposure to arthropods.

Although these persons had neutralizing antibodies as evidence of past infections with this kind of virus, no previous serums were available for tests from these individuals; therefore, no epidemiologic studies of California encephalitis could be made.

California group arboviruses. The original California encephalitis-group virus was isolated from mosquitoes in Kern County, California, by Hammon and Reeves in 1943.[2] In 1945, these same investigators found serologic evidence of infection related to this virus in three young persons hospitalized in California with encephalitis; in addition, neutralizing antibodies were noted in the sera of some human residents and in wild and domestic animals in the area.

In 1961 Burgdorfer et al,[3] of the Public Health Service Rocky Mountain National Laboratory, obtained an isolate serologically related to the California virus, from the blood of a snowshoe hare in Montana, and in 1963 Newhouse et al[4] reported the presence of related neutralizing antibodies in the sera of small mammals in Montana, Michigan, and Southern Canada. Unlike eastern, western, and St. Louis arboviruses, little evidence of California-group virus infection has been found in birds. California-group virus is widespread; closely-related arboviruses have been obtained in recent years from mosquitoes in many areas of the United States, and from South America, Trinidad, and Europe.[5–9]

From the Departments of Preventive Medicine and Pathology, and State Laboratory of Hygiene, University of Wisconsin.

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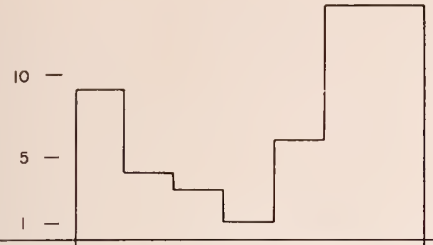


Year	1960	1961	1962	1963	1964	1965	1966	Totals
Number of cases	9	4	3	1	6	14	14	51
Number of patients studied	62	68	96	67	58	318	240	909
Percent with infection	14.5	5.9	3.1	1.5	10.3	4.4	5.8	5.6%

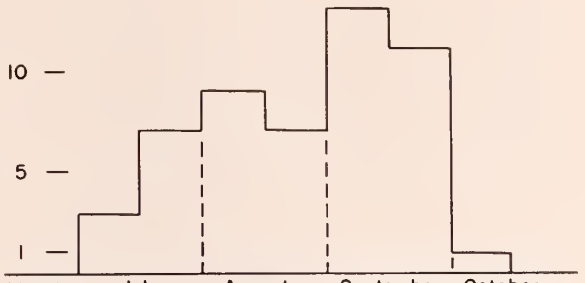
Fig. 1—ANNUAL DISTRIBUTION. Fifty-one cases of California viral encephalitis have been found during a study of paired serums received from 909 patients with febrile illness and central nervous system disease. These include 34 serologically confirmed and 16 presumptive cases, plus one fatal case diagnosed by isolation of the virus. Cases have occurred during each of the seven years studied, with the annual distribution as shown above.

Diagnostic studies. Further studies were then conducted in Wisconsin to detect illnesses that might have been associated with California virus infections.[10] As with the diagnosis of disease associated with other arbovirus infections, evidence of etiology could be obtained either by detecting the appearance of antibodies to the virus between acute and convalescent phase serums collected from the patient, or by isolation of the virus.

Paired sera which had been received by the State Laboratory of Hygiene during 1960 through 1964 from 351 patients with a clinical diagnosis of viral meningitis or encephalitis were selected for study. A hemagglutination–inhibition (HI) test using an antigen prepared from the original California isolate (BFS283) was first conducted on each of the convalescent sera. Antibody evidence of infection with the virus was obtained in sera from 20 patients, and further tests were conducted to establish antibody levels in available paired sera from these 20 patients.

Neutralizing and HI antibodies are usually present a few days after reported onset of disease, while complement-fixing antibodies usually are detectable 10 or 12 days after the onset of illness, with highest titers after three or four weeks.

During the past two years, 30 additional patients have had serologic evidence of infection, and one fatal case has been diagnosed by isolation of the virus.



Month	July	August	September	October
Number of cases	10	16	24	1

Fig. 2—SEASONAL DISTRIBUTION (by two-week intervals). All cases occurred during late summer and fall months.

Distribution of cases. Fifty-one cases of California encephalitis have been diagnosed through the study of paired sera received from 1960 through 1966 at the State Laboratory of Hygiene from 909 patients with febrile CNS disease. This series consists of 34 serologically-confirmed and 16 presumptive cases,[10] plus one fatal case diagnosed by isolation of a California-group virus.[11] The first 21 of these cases were reported in 1965[10] and the rest have been diagnosed since that time. Cases have occurred during each of the 7 years studied, with *the annual distribution* as follows: 9 cases during 1960, 4 in 1961, 3 in 1962, 1 in 1963, 6 in 1964, 14 in 1965, and 14 in 1966 (Fig 1). Although no previous laboratory specimens were available for study, epidemiologic evidence indicates that the virus has been associated with disease in the area for at least 10 or 15 years prior to 1960.

The seasonal distribution of the 51 cases diagnosed in Wisconsin has been limited to the late summer and early fall months, with 10 cases in July, 16 in August, 24 in September and 1 in October (Fig 2).

The age distribution of the Wisconsin patients (Fig. 3) has included the range from 8 months to 17 years, with half of the cases

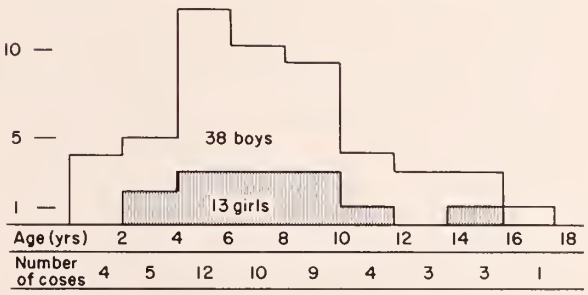


Fig. 3—AGE AND SEX DISTRIBUTION. The youngest patient was 8 months, the oldest 17 years, with half of the cases occurring in children under 7 years of age.

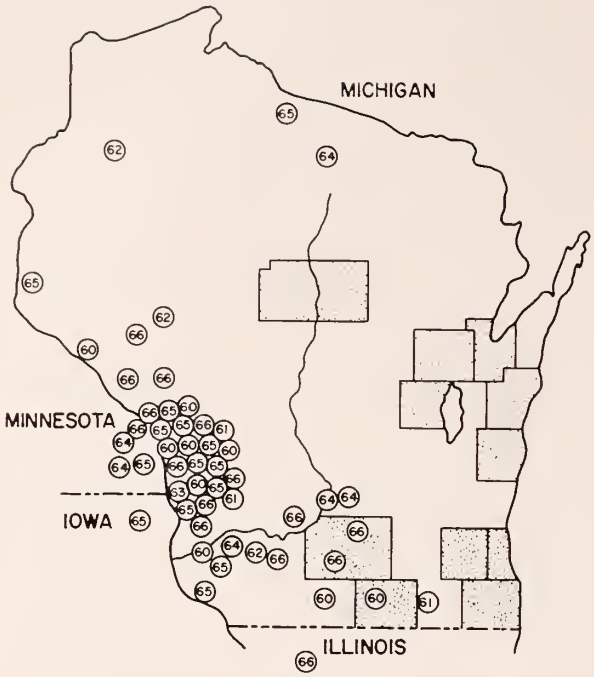


Fig. 4—GEOGRAPHIC DISTRIBUTION. The circled numbers are the areas of most likely exposure of each child hospitalized and year of occurrence. Shaded areas indicate counties with over 75,000 population, predominately urban portions of the state. Most cases have occurred in children living on farms or in forested suburbs.

occurring in children 6 years of age or younger. Three-fourths of these children (or 38) have been boys, and a fourth (or 13) were girls.

The geographic distribution of the cases is shown in Figure 4. In Wisconsin, nearly all of the cases have occurred in children living or visiting the predominately rural western and northern parts of the state. The western part where most of the cases have occurred is primarily an agricultural area with gently rolling hills and long forested valleys, or "coulees," which usually contain spring-fed streams which drain into the Mississippi river valley. Whether the concentration of cases in this area is more dependent on the types of insect vectors in the region or the presence of small wild mammals which are believed to serve as reservoir hosts for the maintenance of the virus in nature has not yet been determined.

A known fatal case. One fatal case has been diagnosed by isolation of a California-group virus from autopsy brain tissues.[11] This occurred in a 4-year-old girl who died with encephalitis in a La Crosse, Wis., hospital in September of 1960.

This human isolate (La Crosse strain) has been used to produce a sucrose-acetone treated complement-fixation antigen for diagnostic purposes, which has been distributed to other diagnostic and research laboratories by the Diagnostic Reagents section of the Public Health Service National Communicable Disease Center in Atlanta, Ga.

During the fall of 1964 following the findings in Wisconsin, the arbovirus section of the Communicable Disease Center, working with personnel in Ohio, Indiana, and North Carolina, reported 38 additional cases. Another case has been reported from Florida.[12] Additional cases have been reported from each of these same states during the past two years.[13-15]

Clinical picture. The clinical picture with this mosquito-borne encephalitis is similar to that observed in other arbovirus infections. Most patients with California encephalitis usually have been hospitalized on the second or third day of illness, with a clinical diagnosis of aseptic meningitis, meningoencephalitis, or encephalitis. Symptoms reported include: fever (100%), headache (95%), nausea or vomiting (80%), nuchal rigidity (60%), and frequently convulsions, restlessness, lethargy, or incoordination. Pleocytosis of the cerebrospinal fluid is common. The disease usually lasts 7 to 10 days.

As with many infectious diseases the subclinical exposure far outshadows the recognized cases. Cases with severe sequelae or fatalities are believed to represent a relatively small proportion of the total number of persons infected. During visits to the homes of most of the Wisconsin cases, made primarily to obtain epidemiologic information following the illnesses, we have noticed no evidence of paralysis. More detailed clinical and neurological studies of these patients are presently underway, conducted in cooperation with Dr. Raymond Chun and others in the Neurology and Pediatrics Departments of the University.

Epidemiology. Studies of the manner in which the virus survives in nature and of the insect vectors which transfer it to animals and man are being conducted in rural areas where infections have occurred.

In these studies, the Zoonoses Research Laboratory of the Department of Preventive

Medicine in the State Laboratory of Hygiene is collaborating with the University Departments of Entomology, Veterinary Science, and Wildlife Ecology. Sera collected from small forest mammals which are believed to be possible reservoirs for the virus are being tested for antibody evidence of infection; and likely insect vectors are being processed for virus isolation. An area of virus activity in a forested area on one of these farms has been located by the presence of antibodies in the sera of small wild animals caught there, and by the acquisition of antibodies by sentinel rabbits placed in cages in the area. Virus has been isolated from *Aedes triseriatus* mosquitoes in the area. Studies will be continued on these farms to determine how the California-group virus remains active year after year in this same area and how human infections are occurring.

SUMMARY

Fifty-one cases of California encephalitis have been found in children hospitalized in Wisconsin from 1960 through 1966.

The clinical picture is usually one of meningitis or encephalitis, including sudden onset with fever, nausea, headache, stiff neck, and convulsions. The diagnosis of California encephalitis virus etiology depends upon the laboratory detection of the appearance of specific antibodies from acute and convalescent phase serums. One fatal case has been diagnosed by isolation of the virus from autopsy specimens.

Histories indicate that most infections have occurred in rural, forested areas in the southwestern portion of the state. Cases have occurred in this area during each of the past seven years, during the late summer and fall months.

Epidemiologic studies in progress so far support the theory that the virus maintains itself in nature in a cycle involving small forest-dwelling mammals and insects, with occasional transfer of the virus to man.

437 Henry Mall (53706).

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TRAUMA AND THE CAVITY BARRIER

WILSON WEISEL, M.D., Milwaukee: *Surg. Gynec.* & Obst. 123:1081 (Nov) 1966.

Although the entity of traumatic diaphragmatic disruption was recognized 300 years ago by Pare, it is a lesion frequently overlooked today with disastrous results to the victim. The incidence of diaphragmatic injury is increasing with the swell of civilian accidents and particularly those due to high velocity vehicular impact.

The clinical findings in an acutely traumatized patient of deteriorating homeostasis and abnormality of the lower chest on physical and roentgen studies should be adequate evidence in experienced hands of diaphragmatic lesions. The most common location for dissolution is the central portion of the left hemidiaphragm.

Practice has proved the efficacy of transthoracic and occasionally abdominal repair of this abnormality and proper replacement of the abdominal viscera. Prompt correction of the physiologic derangement even in the severely traumatized patient is the rule after surgical correction, and late difficulties after repair are rare.

* * *

THE DIAGNOSIS OF early or potential diabetes by observation of changes in small blood vessels has been developed by medical research investigators at the Dallas, Texas Veterans Administration hospital.

Oral Contraceptives and the

"Pharmacologically Altered Internal Milieu"

By WILLIAM DOUGLAS BROOKER, Ph.D., M.D., Milwaukee, Wisconsin

■ MEDICAL SCIENCE is creating within a notable segment of the healthy population a situation which the writer has chosen to call a "pharmacologically altered internal milieu." This refers, of course, to the rapidly increasing numbers of women of childbearing age who are taking the oral contraceptive agents. The "altered milieu" terminology is utilized because apart from the overt side effects requiring withdrawal of the drugs from certain patients, and the varied opinions about the risks of thrombophlebitis and the possibility of altering the incidence of gynecologically oriented cancer, physicians are fabricating a clinically subliminal alteration in endocrine and metabolic balance which must be taken into consideration when a disease does manifest itself in one of the women of this group, especially if the physician is forced to substantiate his suspicions of the diagnosis by means of laboratory tests. The trap for the unwary in this situation lies in becoming oblivious to the fact of altered body chemistry. Because the tablet is taken routinely with regularly spaced interruptions the patient may forget to mention this medication during the history taking. The onus therefore rests upon the shoulders of the physician who must either be aware of this parameter if the patient is one of his own or be astute enough to make a point of asking specifically about the use of these agents.

Also pertinent to the history is the fact that this "pharmacologically altered internal milieu" presents itself in not one, but two distinct and time-dependent phases. First is the transient phase during which there are changes in various contiguous systems sufficient in some instances to require withdrawal of the agent, but which more usually abate, fading into "phase two." The latter phase presumably exists for the entire duration of oral contraceptive utilization. It is during "phase one" that the transient effect on the liver function tests is seen and which abates within two or three cycles of drug usage. The more subtle alterations of body chemistry have not as yet been worked out for this period. It is "phase two," however, of the "pharmacologically altered internal milieu" which largely concerns most physicians and their care of patients routinely taking these medications.

Since the sequential agents are a relatively new approach to oral contraception for the general qualifying patient load, most of the work to be discussed here has been carried out using the combination agents which employ both the progestins and estrogenic substances in a single tablet of constant concentration, usually at a ratio of 10 parts by weight of progestin to 1 part of estrogenic substance. The various milieu changes may be attributable to the estrogenic agent, the progestin, or to the fact that they are being administered concomitantly.

Some authors have attributed the changes noted to a "pseudopregnancy" state; however, the subtle differences between the physiologic state of pregnancy and the pharmacologically induced state with which we are concerned makes glib acceptance of this hypothesis suspect. The alterations may not be attributable merely to the direct effect of these drugs on target organs, but may also be the manifestations of an indirect effect of these agents, to a lesser or greater degree. This indirect effect is due to aspects of drug

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COMMENTS ON TREATMENT

Presented through the cooperation of the Department of Pharmacology, Marquette University, Milwaukee, and the Department of Medicine, University of Wisconsin, Madison

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interaction, such as interference, and employs such parameters as plasma protein carriers and aspects of enzymic or receptor preference and specificity. The oral contraceptive drugs might also be envisioned as having the potential of causing homeostatic imbalance by partially interfering with feedback mechanisms.

The changes caused by the oral contraceptive agents which are responsible for the "pharmacologically altered internal milieu" very rarely ever become clinically overt unless an additional stimulus is added. However, they do exist in large enough magnitude in a sufficient number of patients to plague the physician's decision, especially if they plunge the values being investigated into the beleaguering "grey zone."

Effect on the thyroid. Possibly because the thyroid gland has been traditionally linked to so many gynecologic problems, it was in this area that many of the initial observations of induced metabolic changes were noted. The most common offenders of thyroid function tests are the iodine-containing drugs or x-ray contrast media. It has long been known, however, that increases of estrogen, be they endogenous or exogenous, increase the protein-bound iodine (PBI) levels to those typical of thyrotoxicosis without increasing the uptake of radioactive iodine by the gland. Except in the case of pregnancy, this increase in PBI is not accompanied by an increased basal metabolic rate.

The etiology of this phenomenon is believed to lie in the greatly increased binding capacity of the thyroxine-binding globulin. The capacity increase for triiodothyronine (T_3) is much less, and it has been noted that in both the case of thyroxine and T_3 that there is no measurable increase in the unbound or active forms of these hormones. This may also be the etiology by which estrogens interfere with thyroid tests based on the uptake of radioactive T_3 by red blood cells or by diagnostic resins. By increasing the proportion of bound to unbound T_3, the patient may show hypothyroid values.[1] Progestins alone seem to have little effect on the PBI but this may merely be a dose-dependent phenomenon since doses larger than those found in the oral contraceptives cause increases in PBI in a large number of women.

In studying the effects of short and long-term administration of the oral contraceptives on thyroid function, it was discovered by one team of investigators that as many as 10 different preparations cause an increase in the PBI and a decrease in the uptake of radioactive T_3 by resin in proportion to the amount of estrogenic substance present. If the drugs were withdrawn after one cycle of administration, the values of the altered function tests would return to normal four weeks after the last tablet had been taken. After administration for upwards of a year the time for the values to return to normal after drug withdrawal increased to six weeks. These same investigators suggest that if a woman patient is *successfully* taking the oral contraceptive agents, glandular uptake of radioactive iodine is the most reliable test.[2]

Effect on carbohydrate metabolism. It is known that pregnancy has a diabetogenic effect and that although estrogens are known to prolong the half-life of hydrocortisone,[3] other characteristics of this diabetogenic phenomenon point to another source or sources for the complete etiology. Nuances of steroid diabetes are undoubtedly contributory.

The progesterone-like steroids used in the oral contraceptives are usually altered by a 17-alpha-alkyl substitution to make them orally active. This alteration may be responsible for some of the metabolic effects not seen in the parent compound, including effects on liver function, blood lipids, and carbohydrate metabolism. Alkylated progestational steroids exemplary of this category are those derived from nortestosterone (norethisterone, norethynodrel, ethinodiol diacetate, lynostrenol, allylextrenol, and methylestrenolone) which possess structural similarity to the synthetic anabolic steroids, and may share in some of their metabolic activity. There are, however, other progestins, e.g., megesterol acetate, medroxyprogesterone acetate and chlormadinone, which are derivatives of 17-alpha-OH-progesterone that do not share the same degree of structural similarity to the anabolic agents.

Gershberg and coworkers[4] were some of the first investigators to do controlled clinical trials with the oral contraceptive agents in regard to their effect on blood glucose levels. Further work has substantiated their

investigation in regard to significant elevation of blood glucose after oral administration, but significantly elevated fasting blood glucose levels in the patients taking the oral contraceptives have not been consistently in evidence when compared to control groups, especially in the hands of different investigators.[5] Abnormalities in the curves have been found in about 18% of the general sampling, but when the additional parameter of past family history of diabetes mellitus is added, the percentage rises to 27%. Suggestively elevated values have been reported with intravenous glucose tolerance tests[6, 7, 8] but there is some disagreement whether these values can be classified as *abnormal,* and extension of these clinical trials is being awaited.

The hypothesis advanced to explain the oral glucose tolerance test findings is that progestins stimulate the release and oxidation of free fatty acids increasing lipid metabolism which impairs glucose assimilation and pyruvate oxidation by elevating the acetylcoenzyme A:coenzyme A ratio in muscle and thus suppressing pyruvate entry causing decreased hexokinase activity and impaired glucose uptake and oxidation. There is, indeed, a frequent incidence of elevated blood-pyruvate both during fasting and after the administration of the glucose load. This elevation has also been noted during glucocorticoid therapy.[11] No abnormalities of liver function have been found with currently employed dosages to explain the increased concentration of pyruvate. An interesting additional fact is that although the synthetic anabolic steroids cause prominent changes in liver function and impairment of glucose tolerance test curves, they do not cause measurable changes in pyruvate metabolism.

The changes observed above are similar to those found in late pregnancy,[12] except that the fasting blood glucose is lowered and the intravenous glucose tolerance test is less often abnormal in pregnancy than the oral form of the test. This effect is not as yet completely understood. To be noted, also, is the fact that gestational diabetes is followed within eight years by overt diabetes at a significantly higher rate than is found in the populace not exhibiting this pregnancy change.[13] Furthermore, there has been a significantly increased incidence of vascular changes noted in those individuals exhibiting only asymptomatic or chemically induced diabetes.[14] For these reasons it is important to determine if prolonged administration of estrogenic and progestin medications to healthy women will lead to an increase in chemical diabetes, especially in view of the fact that the reversibility of these changes in carbohydrate metabolism have yet to be evaluated.

Effect on lipid metabolism. Part of the hypothesis for the alteration of carbohydrate metabolism seen when oral contraceptives are taken evokes the increased release and oxidation of free fatty acids. Researchers have not been able to quantitatively correlate dose and free fatty acid changes or glucose tolerance curve variation with the dose needed to cause changes in the other serum lipid fractions. With continual administration of the oral contraceptives there is an increase in the serum of triglycerides, cholesterol and the low, and very low-density lipoprotein levels. Thirty-one per cent of the women receiving the oral contraceptives had fasting serum-triglyceride levels higher than the highest levels found in the control group. Their lipid pattern is similar to that in men and there is thus an increase in the mean atherogenic index. This association with increased serum-lipid levels and atherosclerosis has been shown in the absence of any drug therapy in both retrospective[15] and prospective[16] studies in both men and women.

Progesterone itself appears to have no significant effect on the serum lipid levels; whereas, the progestins administration causes changes in the serum lipid levels such as are seen with the oral contraceptives. Orally active androgens given during estrogen therapy have been noted to cause reversal in the established lipid effect and occasionally have resulted in strikingly elevated low density lipoproteins and total cholesterol levels.[17, 18, 19] Since the progestins in many preparations have some andogenic activity the foregoing observation may have some validity in the lipid picture they produce. This pattern differs from that seen in pregnancy in which *both* the triglyceride and total cholesterol fractions are similarly increased, whereas progestins cause an increase in the triglyceride which *exceeds* that of cholesterol. Androgens solely administered cause an increase in low-density lipoproteins and a decrease in the high fraction, while

the serum triglycerides and total cholesterol are essentially unchanged.

Effect on liver function. Since the majority of drugs are biotransformed in the liver which is the site of a multiplicity of enzymic and metabolic functions, it is logical that investigators should turn to hepatic mechanisms early in their plight for an explanation. It is known, for example, that in general during continuous drug administration there are adaptive cellular and enzymatic changes taking place in the liver, consisting primarily of an increase in the smooth endoplasmic reticulum and biotransforming capacity.[20,21] Liver function studies in this instance tend to remain normal. In the case of the progestins, the larger the dose, the greater the incidence of bromosulfophthalein (BSP) retention in a test group, but in the individual the response need not be dose-dependent. The defect incurred appears to be in excretion and not in conjugation of the BSP.

Jaundice has been reported in an incidence of 1:10,000 or less. It occurs: (a) in women with recurrent cholestasis of pregnancy exhibiting jaundice and pruritus during the first month of therapy, the etiology of which is thought to be greater sensitivity of their bile secretory apparatus to both progesterone and progestins; (b) as cholestasis with no signs of hepatocellular damage or hypersensitivity, the etiology here probably representing a direct effect of the progestins or estrogens on the bile secretory apparatus; or (c) with increased transaminase or isocitric dehydrogenase activity and tissue eosinophilia indicating a hypersensitivity type of reaction. The tests measuring the impairment of the bile secretory apparatus, in decreasing order of sensitivity, are: BSP retention, serum alkaline phosphatase, serum bilirubin concentration and the concentration of serum cholesterol. Both the 17-alpha substituted compounds and the nonsubstituted one can produce BSP retention and canalicular dilatation. The presence of the 19-CH_3-group is not a major factor in this action, but appears to potentiate the activity caused by the 17-alpha-alkyl substitution.

In 7% of the women studied, serum glutamic pyruvic transaminase was elevated and in 6% serum glutamic oxaloacetic transaminase was similarly increased. Agents which cause a decrease in protein synthesis and biotransformation mechanisms severely interfere with liver function and may be properly termed *hepatotoxins*. Hepatotoxicity shows both species and individual variation. The oral contraceptives generally are not considered to affect either the specific protein synthesis in the liver, nor the conjugating systems and hence are not considered hepatotoxins. As stated previously, if the symptoms of this transient phase are not severe enough to require the discontinuing of therapy, most changes in liver function will abate beyond detection in six to nine weeks despite continued administration.

Thus we have seen that these oral contraceptive agents are indeed producing a "pharmacologically altered internal milieu" which demands added alertness of physicians treating the segment of the population involved. Our sphere of knowledge in this area is rapidly expanding and it behooves medical practitioners to keep abreast of the facts, when they are conclusively presented, enabling him to better care for these women. As time passes, greater clarification will take place, hypothesis will become fact and the physician will be better guided along the paths of these "new norms."

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WISCONSIN'S HEALTH

by E. H. JORRIS, M.D., State Health Officer

COURSE FOR REACTIVATED NURSES IS WELCOMED

Wisconsin nursing homes and the State Board of Health are engaged in a program to help ease the shortage of registered nurses.

Since 1952 the State Board of Health has been working to upgrade Wisconsin nursing homes. A carefully planned program to achieve this by a series of ever-improved standards over a period of years was worked out with the cooperation of nursing home administrators. In 1964 these rules provided that nursing homes be classified according to the services available and the top category in this classification required that a registered nurse be employed. When Medicare benefits in extended-care facilities became available in January 1967, one of the requirements was that eligible facilities employ registered nurses in specific capacities.

A study made by our Division of Research indicates that in March 1967 there was the equivalent of 753 full-time registered nurses employed in Wisconsin nursing homes. The actual count of nurses employed is greater than that figure because many nurses work only part time and their hours of work were computed to an equivalent of full-time nurses.

More than a year ago the nurse consultant unit of the Division of Hospital and Related Services asked questions of nursing home administrators in the nine-county State Board of Health district surrounding Madison. How serious was the shortage of registered nurses? Were nursing homes finding it possible to persuade inactive registered nurses to return to nursing occupations? Could more nurses be encouraged to return to active nursing if they could attend frequent classes that would give them both refresher material and information on newly developed techniques and drugs for the care of nursing home residents?

The response was urgently affirmative and a pilot project was set up. Class enrollment was limited to registered nurses and about 40 RNs attended. Many of these nurses had been inactive for several years. Classes were scheduled once each month and each session was 2 to 4 hours.

Early sessions were necessarily focused on refresher material. As the classes progressed there was a greater use of resource personnel from all disciplines in the medical and paramedical fields. An especially pleasing development has been the willingness of physicians, dentists, and other professional people who are concerned with the care of the elderly to participate in these courses.

At the May Annual Meeting of the State Medical Society, the House of Delegates approved a recommendation of the Commission on Hospital Relations and Medical Education that nurses, not presently active in the profession, take refresher courses and return to the profession of nursing on some basis.—EDITOR

The pilot program pioneered in the Madison-area district is now being expanded to all areas of the state. Initial meetings have already been held in six of the seven remaining State Board of Health districts. The reception has been enthusiastic. Training courses for re-activated registered nurses promise to become a valuable part of the public health program.

NARCOTICS REGISTRATION DEADLINE IS JULY 1

All physicians registered under the Harrison Narcotic Act or the Marihuana Tax Act must re-register and pay a tax of $1.00 by July 1. Failure to comply with the law may result in severe penalties. If you have not received forms for separate registration and inventory of narcotics and marihuana, contact the Office of the Director of Internal Revenue, Federal Building, Milwaukee 53201. Physicians with more than one office must register for each since each office is required to have a separate registration number.

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EDITORIALS

D. N. GOLDSTEIN, M. D., *Editorial Director*

Clark's Chronicle

■ PAUL F. CLARK, PH.D., has written a fascinating history of the University of Wisconsin Medical School which should be in the library of every doctor in the state. As a narrative of development of the school and as a portrayal of the men who made significant contributions to its growth, the book contains invaluable insights that could have come only from Doctor Clark.

Doctor Clark arrived in Madison as an associate professor of medical bacteriology in 1914, seven years after the Medical School was established as a two-year, pre-clinical course. When he retired in 1952, the Medical School had become one of the major teaching and research institutions in the world. Doctor Clark was intimate with many of the giants of medicine in Wisconsin whose names are identified with its greatness.

The book is by no means stuffy. Neither a dry chronology nor a potpourri of trivia and gossip, it deals with important historical material. Although he eschews internal politics and the clashes of personalities and ambitions that might illuminate some of the developments, Doctor Clark's description of the characters in the drama of the school's history glows with the warmth of personal affection and respect.

Alumni of Wisconsin's Medical School will find much that is nostalgic in the book. It contains material that has not been published before about many of the figures that inhabited the formative years of our careers. Alumni of other schools who now practice in Wisconsin will receive great insight into the background of the present academic condition in Wisconsin.

The University of Wisconsin Medical School, A Chronicle, 1848–1948, was originally suggested to Doctor Clark by Dr. Mischa Lustok, with the enthusiastic endorsement of a committee of the Wisconsin Medical Alumni Association. The choice was an excellent one, for Doctor Clark is fluent, disciplined and magnificently competent. It is available from The Wisconsin Alumni Association, 333 N. Randall Avenue, Madison, at $10.00 per copy. All royalties derived from the sale of book have been donated by Doctor Clark to the Alumni Association.

As Dr. William S. Middleton observes in his foreword to the book, "Dr. Clark has wrought a splendid lasting documentary account of the University of Wisconsin Medical

School. Assuredly, it will take its proper place in the archives of our great Medical School and University as a milestone of reference." If you don't already own it, order your copy now.—DNG

Regressive Legislation

SENATOR RUSSELL LONG (Dem., La.) thought he could force a reduction in the cost of prescription drugs by compelling doctors to use generic names of pharmaceuticals ordered for Medicare patients. His bill designed for this purpose (introduced in the 89th Congress) ran into trouble, however, when the Department of Health, Education and Welfare, which administers Medicare, found that there were important therapeutic differences in various brands of the same drug and that it couldn't require use of generic names until the question of those differences was resolved.

Now, switching his approach slightly, Senator Long has introduced a new bill in the Senate which would permit Social Security and welfare programs to pay for drugs only according to the price listed in an official "Formulary of the United States." This listing would include all drugs and biologicals now contained in the U.S. Pharmacopeia, the National Formulary, the U.S. Homeopathic Pharmacopeia, New Drugs, or Accepted Dental Remedies, provided they are favorably evaluated by these lists. It would also include trade-name drugs or combination products if the committee that sets up the new formulary agrees that they have distinct, demonstrated therapeutic characteristics not otherwise available, are available at a lower price than similar drugs available by established name, or are generally available and sold only under trade names and are the only products of a quality acceptable to the committee.

The committee compiling the official Formulary would also be empowered to establish a "reasonable cost range" for any pharmaceutical listed. In addition, the new bill amends existing legislation to give the Secretary of Health, Education and Welfare the power to require registration numbers, presently assigned by the Federal Drug Administration to pharmaceutical manufacturers and packagers, be imprinted on the labels of all drugs. If a prescribed drug does not bear a registration number for any reason—and a number of them are spelled out—it would not be eligible for reimbursement under the federal welfare programs.

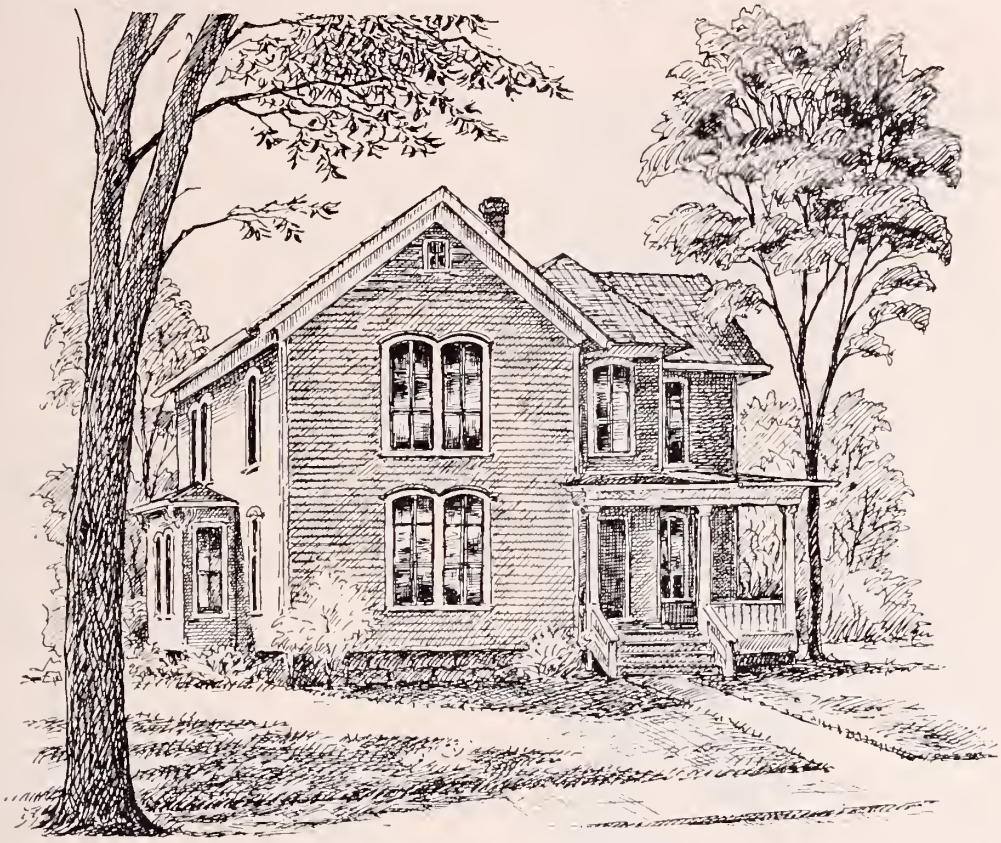
The implications of the bill are obvious. The nine-man committee that prepares the Formulary is given ultimate selection over the drugs that a doctor can prescribe for any patient covered by any government program. As tax-supported medical care pervades, it means that a government committee will decide what drugs a manufacturer will be permitted to market and at what price.

The provisions of Senator Long's new bill seem to add red tape by the mile: the registration numbers on the label of every package (which will undoubtedly have some significance in the reimbursement process), outside control of the day-to-day activities, even including a possible batch-by-batch testing program, capricious withholding of products from the market for unnecessarily long periods while the bureaucratic wheels grind, overlapping supervision by the Formulary committee and the FDA which is charged with responsibility for testing drugs for purity and effectiveness, hearing and litigation mechanisms, and all the other evils that go with pointless bureaucratic control.

For the doctor, the new bill means additional restrictions on his practice of medicine. At best a formulary of any kind is difficult to use. They are seldom available at the moment a prescription is written, and they are so quickly out of date that even if they were available in vest-pocket editions a patient could be deprived of the correct treatment.

Compulsory use of a formulary enters the doctor-patient relationship in an arbitrary and unnecessary manner. In the vast majority of instances, the pharmaceutical prescribed by the doctor would probably be the one approved by the formulary. In the remainder of the instances, the doctor would undoubtedly be able to give a cogent reason for his choice of a drug for a particular patient. He could give it if he had to do so, but it is unreasonable for him to be compelled to do so by a federal agency. Restricting the doctor's choice of treatment simply reduces the quality of medical care.

Hopefully, common sense will prevail against this bill as it apparently did against the last bill Senator Long introduced dealing with prescription drugs. If it doesn't, the principal loser will be the patient under tax-supported medical care.—DNG



Cornelius House, first student clinic

THE UNIVERSITY OF WISCONSIN MEDICAL SCHOOL

A Chronicle, 1848–1948

By Paul F. Clark

In 1907, after stormy debate, the Wisconsin legislature approved the establishment of a two-year Medical School. The building of Wisconsin General Hospital provided the necessary clinical facilities for a full four-year school, which was approved by the legislature in 1925. The medical faculty began slowly moving out of attic and basement laboratories and expanding into specialized departments in new laboratories and classrooms. Nearly eighty years had elapsed since the incorporation of the University in 1848 with medicine as one of its four proposed departments.

Writing in terms of human relationships from the vantage point of personal experience, Paul F. Clark, Emeritus Professor of Medical Microbiology, reconstructs this history of the Medical School with insight and admiration. His vignettes of fellow faculty members are drawn with a fluent pen which sketches personal habits and hobbies along with professional dreams and contributions.

Published for the Wisconsin Medical Alumni Association. 286 pages, 54 illus. $10.00

At your bookseller or write direct.

THE UNIVERSITY OF WISCONSIN PRESS
BOX 1379
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THINGS A LITTLE STRAINED AT HOME??

She may be weary: women do *get weary! You spent your day-off with the utilization committee—tonight, three patients phoned during dessert alone—tomorrow night, a closed circuit craniotomy for you, Andy Griffith reruns for her. Take her away from all this!*

Make a Get-Away Weekend—just the two of you—to Prairie du Chien and the Museum of Medical Progress. Spend Saturday at the air-conditioned Museum for a delightful refresher on your colorful heritage: the dioramas of highlights; Beaumont and St. Martin; the walk-in, 1880 drugstore; the horse-and-buggy doctor. (You can make subtle remarks about how tough **his** *wife had it.)*

True, "Prairie" isn't Chicago—no Playboy Club or White Sox—or noise or dirt or rush or high prices. Instead, it's clean, restful and fun! Poke around its shops and its history. Play golf and swim. Enjoy incomparable scenery; gaze lovingly at her over a gourmet dinner of steak or fresh Mississippi fish. Go ahead. Show her what a devoted, romantic blade you still are!

The Museum of Medical Progress and Stovall Hall of Health

Prairie du Chien, Wisconsin

Owned and operated by the Charitable, Educational & Scientific Foundation of the State Medical Society of Wisconsin.

SPECIAL TO THE JOURNAL

Cardiac Criteria for Workmen's Compensation Act of Wisconsin

By GEORGE A. HELLMUTH, M.D.
Milwaukee, Wisconsin

OUR EXPERIENCE with rehabilitation of the unemployed cardiac case in the Marquette University School of Medicine Cardiac Work Classification Unit (conducted in cooperation with the Curative Workshop of Milwaukee, Inc.) since 1958 pointed up to us the need for a comprehensive investigation of work and the cardiac in Wisconsin. We needed to find out why so many individuals who had recovered from acute heart conditions to the point where they could work with no or minimal restrictions still met such frequent frustration when seeking new jobs or returning to former ones.

In 1962 the Wisconsin Heart Association's Heart Disease and the Law Committee initiated a grant-supported research project on work and heart disease. Subsequently a multidiscipline group called the Marquette University Steering Committee on Heart Strain and Trauma (MUSCHST) was organized to assist in working out practical resolutions and to communicate the results of our studies conducted by the Medical School to policy-making bodies and to the general public. Committee membership is comprised of representatives of the Marquette University School of Medicine (cardiovascular and industrial certified board members, the latter Emeritus Professor and former head of the Division of Preventive Medicine acted as chairman), Law School and College of Business Administration, State Medical Society of Wisconsin, Wisconsin Heart Association, Industrial Commission, State Division of Vocational Rehabilitation, claimant and defense attorneys, labor unions (AFL–CIO), management (Wisconsin Manufacturers Association) and insurance carrier.

In pursuit of our goal of broadening the employment opportunities in the rehabilitation of the heart patient, we found it necessary to explore the following research areas: evaluating the medical basis for Workmen's Compensation awards in cardiac claim cases in Wisconsin;[1] drafting guidelines for physicians and lawyers to aid in the adjudication of such claims;[2] attorneys' attitudes toward medicolegal aspects of Workmen's Compensation;[3] Wisconsin employers' policies regarding hiring or retaining the cardiac worker;[4] and devising a guide for clinical assessment for work capacity and work prescription.[5] Our discussion in this paper will concentrate on our completed studies of Workmen's Compensation awards, a model for medicolegal guidelines, and deliberations of the 1967 Workmen's Compensation Advisory Committee. Data on employers' and attorneys' attitudes and vocational rehabilitation is being prepared for publication.

From the Cardiac Work Classification Unit, Department of Physiology, Marquette University School of Medicine, and Curative Workshop Adult Rehabilitation Center.

MEDICAL BASIS FOR AWARDS

Suspecting employers' fear of liability under Workmen's Compensation as a major block to their ready acceptance of the cardiac employee, it was decided to begin with an investigation of awards made to heart attack victims under state Workmen's Compensation law.[1]

In our first study we examined Wisconsin Industrial Commission files for the 1953 to 1962 period during which 481 cases of alleged cardiac injury were recorded. We noted that the number of cardiac-injury cases has increased since 1956 (Table 1). Monetary awards also increased.

We were pressed to ask the next question: were these awards truly deserved? Using American Heart Association criteria for determining causality, we found that approximately half of the compensated and compromised award cases made during the 1961–1962 biennium studied could *not* be justified medically. The American Heart Association takes the position that heart failure of the congestive, coronary insufficiency, or myocardial infarction types "shall be considered related to physical or emotional exertion only if the heart failure occurs during the actual period of stress clearly unusual for the individual . . . in view of the current absence of acceptable scientific confirmation, heart disease except in the rare instances mentioned (e.g. silicosis, cor pulmonale),* shall not be considered as arising out of employment."[6]

Physicians testifying for claimants and respondents often disagreed on the probability of work-related exertion as a causative factor, and the medical testimony generally did not hold up well to the AHA criteria.

Under the Workmen's Compensation Act of Wisconsin awards for cardiac disturbances occurring during employment are made on the basis of medical causation—that such disturbances are a "reasonable probability" resulting from the physical or emotional demands of the patient's work. This is not

* parentheses ours.

TABLE 1.—*Legal Disposition of Cardiac-Injury Claims, 1953 to 1962**

Biennial	No. Cases	Compensated Claims			Compromised Claims			Noncompensated Claims	Award, % Cases
		No. Cases	Biennial Amount	Average Amount	No. Cases	Biennial Amount	Average Amount	No. Cases	
1953 to 1954	78	12	$ 51,636	$4,302.66	3	$ 3,878.00	$1,292.66	63	19.2
1955 to 1956	78	7	17,596	2,513.71	4	11,134.00	2,782.50	67	14.1
1957 to 1958	106	8	36,446	4,555.75	11	40,415.00	3,674.09	87	17.9
1959 to 1960	113	13	62,065	4,774.23	3	12,250.00	4,083.33	97	14.2
1961 to 1962	106	18	102,421	5,690.05	8	36,491.00	4,561.37	80	24.5
Total	481	58	$270,160	----	29	$104,164.00	----	394	18.1
Yearly average	48.1	5.8	$ 27,016	----	2.9	$10,416.40	----	39.4	----

*Heart-failure cases closed, 1952 to 1963, excluding reopened cases (Industrial Commission of Wisconsin, Statistical Division, Dec. 2, 1964). (Reproduced from the Journal of the American Medical Association.[1])

a legal but rather a medical problem, and only factual medical opinion can lend accuracy to any such determination.

Conflicting medical testimony, however, has been a problem in Wisconsin, one about which lawyers and commissioners frequently complain.[3] It was incumbant upon us, therefore, to find ways to make medical testimony more thorough and consistent. To test our belief that this is possible, we submitted the most complete medical histories of the 1961 to 1962 cases of compromised and compensated claims to a team of seven physicians (two general practitioners, three internists, and two cardiologists). All were asked to follow the American Heart Association criteria for determining causality. The three known to have had the greatest training and experience with cardiac cases in practice and in court consistently agreed with each other, while the less knowledgeable physicians showed wide disagreement.

PROPOSED WORKMEN'S COMPENSATION MODEL FOR RULES OF PRACTICE

The Marquette Steering Committee appointed an ad hoc law and heart subcommittee, chaired by the Dean of the Law School, and assigned the members to draft rules of practice (published regulations found in most states pertaining to the manner of appearance of witnesses and presenting evidence before the Commission). The Rules were to be formulated on the basis of our first study and the American Heart Association criteria for causality. This document would be submitted to the Industrial Commission of Wisconsin for proposed use as guidelines in the adjudication of Workmen's Compensation cardiac-disease claims. They were drafted with three objectives in mind:

(1) to clearly define the role of medical testimony in the settling of cardiac claim cases;

(2) to facilitate better interprofessional communication among attorneys, physicians, and commissioners; and

(3) to stress the importance of postmortem examinations.[2]

The suggestions which follow were approved by the parent (MUSCHST) committee and the State Medical Society of Wisconsin through its Committee on Occupational Health. One dissenting opinion was made by a legal union representative serving on the MUSCHST and Law and Heart Subcommittee. The Rules in turn were submitted to the advisory committee of the Industrial Commission in August of 1966. The following document is the model for rules as proposed:

WORK AND HEART DISEASE IN WISCONSIN

Workmen's Compensation Proposed Rules of Practice

(Quotation from the Journal of the American Medical Association)[2]

NOMENCLATURE AND DEFINITIONS OF HEART DISEASE

Arteriosclerosis is a chronic, degenerative, and gradually progressive disease, characterized by hardening and thickening of the blood vessels (arteries) of the body. The scientific cause (etiology) for arteriosclerosis is unknown.

Coronary arteriosclerosis applies to the coronary blood vessels (arteries) supplying blood (containing oxygen) to the heart. The development (natural history, i.e., onset to recovery or death) of arteriosclerosis in the coronary or other arteries usually requires years to develop before any functional disturbances (symptoms or signs) of impaired heart function occur. Coronary arteriosclerosis does not manifest disturbances (symptoms or signs), until the process (advanced arteriosclerosis) develops to the point of actual interference with the circulation of blood (containing oxygen) through the coronary arteries and adversely affecting the heart muscle (myocardium), which is the source of the cardiac symptoms and signs.

Thus, adverse effects on the heart (cardiac organ) occur only when narrowing or occluding of the coronary blood vessels (arteries) has progressed to reducing or blocking the coronary arterial blood flow below the needs of the heart muscle. Coronary arteriosclerosis may be associated with one or more of the following pathological (abnormal structure and function) conditions: coronary (blood flow) insufficiency from narrowing of the arteries, resulting in temporarily and partially impaired arterial (oxygen) blood circulation (angina pectoris [chest pain]), myocardial ischemia (inadequate oxygen),

usually with brief (reversible) heart muscle disturbances (exertional-excitement pain) and, ordinarily, recovery within minutes. A more advanced degree of blocking of the coronary arterial blood flow may produce a severe degree of oxygen (blood flow) deprivation commonly resulting in destruction (irreversible) of a small part of the heart muscle. The latter condition (death of muscle) is called a myocardial infarction and may occur with or without a total arterial (blood flow) block from a thrombosis (occluding arterial blood clot, thickening of the arterial wall, and/or hemorrhage in the wall of the artery). Scientific evidence indicates that the point of time at which a myocardial infarction occurs with clinical symptoms or signs results from factors largely unknown, but occurs most frequently during sleep and rest, ordinary physical or mental activity, and infrequently, during unusual physical or mental activity.

Myocardial infarction may produce blood clots on the injured heart wall (mural thrombosis). Part or all of the clot may become dislodged, i.e., process called embolization, and circulate into progressively smaller arteries until the clot becomes lodged in an artery, cutting off circulation, e.g., to the brain, resulting in a stroke. Myocardial infarction may also produce congestive heart failure (weakness of heart function, with excess body fluid, i.e., edema); myocardial fibrosis (scar tissue in the heart muscle wall from healing, with or without functional impairment); or serious arrhythmias (heartbeat irregularities resulting in inadequate blood circulation throughout the body).

The term "heart attack," if used, will be understood to mean "acute (sudden) coronary episode" with one or more of the following types: myocardial infarction, congestive heart failure, or serious arrhythmias.

The cause (etiology, i.e., specific medical cause) of arteriosclerotic coronary heart disease is unknown. There is no scientific evidence indicating occupational (etiology) origin. Usual physical or mental activity or sleep or rest are not known to be precipitating factors in an acute coronary episode. However, physical or mental exertion (stress or strain), medically determined to be definitely unusual and excessive for the particular individual, which produces symptoms or signs during the actual period of stress or strain, or immediately following, may precipitate, in a very small segment of the coronary disease population, an acute coronary episode.

An acute coronary episode, most frequently associated with a myocardial infarction, is characterized clinically by a history (story) usually of one or more of the following symptoms or signs: chest pains, radiating not infrequently to one or both arms; sweating; shortness of breath; apprehension; weakness, with signs of fall in blood pressure; fever; blood changes (leukocytosis, increased sedimentation rate, and transaminase level); an electrocardiographic pattern that is usually consistent with an acute myocardial infarction.

Essential hypertension (unknown cause, high blood pressure) is a functional (physiologic) disturbance affecting adversely the arterial blood vessels and the heart. Etiology is unknown.

Rheumatic heart disease is the result of an inflammation of the heart called rheumatic fever. Rheumatic heart disease usually results in deformities of the heart valves, congestive heart failure, arrhythmias, mural thrombi, and/or embolisms. It has no known scientific occupational origin or medical causal (etiology) relationship to physical or mental stress or strain. In the presence of impaired heart function (heart enlargement, failure), usual and unusual physical or mental stress or strain may aggravate the condition in the natural history of the disease.

Subacute bacterial endocarditis is an inflammation of the heart valves caused by a bacterial blood infection. It is etiologically unrelated to employment or to occupational stress or strain. Usual or unusual physical or mental stress or strain may aggravate the condition, depending upon the degree of heart disease involvement.

Syphilitic heart disease is a condition involving the origin of the two coronary arteries, the aorta (large artery leaving the heart) and its valve, caused by spirochete microorganism impairing the aortic valve function and the coronary blood circulation to the heart. Physical or mental stress or strain may aggravate the condition, depending upon the degree of heart disease involvement.

Congenital heart disease is a defect (malformation) arising from birth and by definition is not etiologically known to be caused by occupational stress or strain. Usual or unusual physical or mental stress or strain may aggravate the medical condition, depending upon the degree of heart disease involvement.

Pulmonic heart disease (cor pulmonale) is heart enlargement arising from pulmonary (lung) diseases, the latter producing narrowing of the pulmonary arteries, thus impairing blood circulation through the lungs, increasing pulmonary blood pressure, and demanding increased heart work. Those lung diseases which result in diffuse, lung-scarring (fibrosis) may be occupationally causal (etiologic), e.g., silicosis (inhalation of silicon dust), and may produce pulmonary heart disease. Localized (nodular, i.e., nondiffuse) lung-scarring does not produce cor pulmonale.

Traumatic heart involvement (external physical source) includes penetrating injuries to the heart (lacerations) or blow injuries (nonpenetrating) to the chest wall and to the heart (contusions). These conditions may be causally related to occupation.

DIAGNOSIS, POSTMORTEM EXAMINATIONS, AND TESTIMONY

The Commission will require that the complete cardiac diagnosis be accurate and made on adequate data, including the etiologic classification (medical cause, e.g., coronary heart disease), anatomical

TABLE 2—*Classes of Organic Heart Disease: Guide for Evaluating Impairment of the Whole Man**

Class I Prime	Class I	Class II	Class III	Class IV
Impairment none	Impairment 0–25%	Impairment 25–50%	Impairment 50–75%	Impairment 75–100%
Energy expenditure over 7 calories/min	Energy expenditure continuous up to 5 calories/min, intermittent to 6.6 calories/min	Energy expenditure continuous up to 2.5 calories/min, intermittent to 4 calories/min	Energy expenditure continuous up to 2 calories/min, intermittent to 2.7 calories/min	Energy expenditure up to 1.5 calories/min
No c-v symptoms with any type of activity	No c-v symptoms with ordinary activity	C-v symptoms with ordinary activity; none at rest	Less than ordinary activity causes symptoms; none at rest (except angina)	Symptoms even at rest
Walking, climbing stairs freely, and all activities of daily living do not produce symptoms	Walking, climbing stairs, and usual activities of daily living do not produce symptoms	Walking on level, climbing one flight of stairs (average pace) and usual activities of living do not produce symptoms	Walking more than one block on level or climbing one flight of stairs (average pace) or usual activity of daily living produce symptoms	Performance of any of activities of daily living beyond personal toilet or its equivalent produces increased discomfort
Continuous (3 min or longer), very severe (rapid action of mass musculature) physical exertion, hurrying, hill climbing, severe or competitive recreation do not produce symptoms	Intermittent (2 min or less) severe physical exertion, hurrying, hill climbing, active recreation, and marked emotional stress do not produce symptoms	Emotional stress, hurrying, hill climbing, active recreation, or similar physical activity produce slight symptoms	Emotional stress, hurrying, hill climbing, active recreation or similar activities produce marked symptoms	Symptoms increase with emotional reaction; any physical activity increases discomfort
Signs of congestive heart failure are not present	Signs of congestive heart failure are not present	Signs of congestive heart failure are not present	Signs of congestive heart failure may be present, and if so, are usually relieved by therapy	Signs of congestive heart failure, if present, are usually resistant to therapy

*Adopted with revisions from the American Heart Association (New York Heart Association)[7], American Medical Association (Committee on Medical Rating of Physical Impairment)[8] and Work and Heart Disease in Wisconsin.[2]

classification (structural change, e.g., healed myocardial infarction), physiological classification (heart action, e.g., auricular fibrillation, a type of arrhythmia), and impairment (evaluation of degree of heart function involvement, e.g., impairment, class II, 25 to 50% as outlined in Table 2).

If an accurate diagnosis in a fatal case cannot be made by clinical history, physical examination, electrocardiogram, x-ray, or pertinent blood studies, a postmortem examination must then be performed, unless valid objections are raised, for example, on religious grounds. As a matter of policy, in all cases in which death occurs under circumstances giving rise to a Workmen's Compensation claim, a thorough postmortem examination is strongly recommended.

All testimony is required to be to a reasonable medical probability. Medical testimony to a mere possibility, or based on speculation and conjecture, is not adequate. A medical opinion must be knowledgeable, unbiased, and based on the most modern scientific data; and the testifying physician must be given an opportunity to fully express his professional opinion.

CAUSALITY

A normal heart has sufficient strength to maintain adequate function during usual and unusual physical and mental stress. In the presence of known or unknown heart disease, the occurrence of heart symptoms or signs during working hours (arising in the course of employment), indicates that the heart is involved, but it does not necessarily mean that the underlying heart condition has been caused or aggravated by employment (arising out of employment), except when unusual physical or mental exertion, medically determined to be definitely unusual and excessive for the individual, occurs at the time of, or immediately after, the stress. This relationship is the only one medically agreed upon as a possibly acceptable work-connected incident (unusual stress, strain) considered to "light up" or aggravate or expose pre-existing cardiac disease, perhaps resulting in one or more of the following conditions: acute myocardial infarction with or without coronary occlusion (survival or nonsurvival); coronary insufficiency (angina pectoris) or serious arrhythmias (with or without heart disease) occurring for the first time; angina with sudden death and/or myocardial infarction and/or congestive heart failure from various etiological heart (external trauma, disease, e.g., rheumatic, congenital) conditions.

Causality in traumatic (penetrating and nonpenetrating) injuries with symptoms and signs of cardiac involvement must be demonstrated within a 24-hour period.

The Commission will adhere to the principle that the alleged causal relationship of an industrial incident to a heart involvement claim can be settled fairly only by recourse to adequate medical testimony.

MEDICAL IMPAIRMENT AND DISABILITY

Approximately 90% of all cardiac claims involve arteriosclerotic coronary heart disease (acute myocardial infarction, angina pectoris, or congestive failure). They are unstable medical conditions, with varying periods of recovery and recurrence. Usually a period of not less than six months should elapse before determination of permanent medical impairment, if any, after an acute coronary episode. It may be necessary in heart disease cases to reevaluate the degree of impairment rating every six months to a year depending upon circumstances.

Evaluation should be determined after maximal treatment and rehabilitation have been in effect. Impairment (physician's responsibility) shall be estimated in terms of degree of the patient's heart involvement, as compared with total impairment of the whole man. The Commission recognized that it is difficult to translate impaired cardiac function as a contributory factor within the statutory meaning of disability, i.e., combined medical, social, and economic factors. Nevertheless, the following practical guide (Table 2) for evaluating cardiac impairment, although not all-inclusive, may be helpful as a basis for administrative rating of permanent disability.

Cardiac disease that does not interfere with all activities of daily living and work shall not constitute an impairment (class I prime). Where the patient is able to perform any work, including the performance of usual activities of daily living, and all but the most strenuous physical and mental activity, his impairment in terms of the whole man shall be evaluated as minimal (class I, 0–25%). Where the limitations prevent prolonged and more than ordinary physical activity at work, but do not interfere with usual activities of daily living, the impairment shall be moderate (class II, 25–50%). Where the patient is unable to perform anything but sedentary or sheltered work and has difficulty (cardiac symptoms) with the performance of usual activities of daily living, he shall be classified as severe (class III, 50–75%). Where the patient evidences cardiac symptoms on the performance of any activity, and which may be present even at rest, his case shall be categorized as very severe (class IV, 75–100%).

INDEPENDENT EXAMINATION AT DIRECTION OF INDUSTRIAL COMMISSIONERS

The Commission, at any time after the application for adjustment has been filed, either before or after the hearing, will select from an available list one or more physicians certified by the American Board of Internal Medicine (preferred subspecialty in cardiovascular disease) or other physicians qualified by broad experience and recommended by the State Medical Society of Wisconsin and by at least one of the two medical schools in Wisconsin to examine the patient or to review medical data. Such physicians shall prepare a written report to the Commission, which shall be furnished to all parties in interest. At the time the matter is scheduled for a hearing, the party desiring to examine the independent expert medical witness shall make arrangement for his attendance. Otherwise, the report can be received only by stipulation.

REHABILITATION

The commission urges the full use of rehabilitation procedures as cited in rehabilitation laws of the Workmen's Compensation Act of Wisconsin.

REVIEW

These rules are subject to review every six years or sooner in accordance with advances made in the scientific knowledge and techniques of heart disease.

DELIBERATIONS OF THE 1967 WORKMEN'S COMPENSATION ADVISORY COMMITTEE

The Advisory Committee (consisting of five voting members, both management and labor, three nonvoting members representing causality insurance companies) on Workmen's Compensation claims reported (from February 3, 1967, minutes) that the proposed cardiac Rules of Practice were not accepted on the basis that such claims "were being satisfactorily handled by the Commission at the present time."[9] While the Commission examiners have not adopted the tests for work involvement printed in the *Journal of the American Medical Association* 198:9–15 (Oct 3) 1966, and 198:1335–1340 (Dec 26) 1966, as recommended by Hellmuth et al (Rules of Practice), it was stated at the meeting that all compensated heart claim cases require by the Commission a showing of physical or emotional stress and strain in excess of that ordinarily required by the normal activity of daily living. Such claims must arise out of employment and the burden of proof rests upon the claimant. In view of these general statements on report of the Commission, there was no effort on the part of the sponsor (of the rules) to pursue at this Committee session specific adoption of the proposed cardiac document.

In the ensuing discussion on usual and unusual stress and strain doctrine, it was pointed out that since 1960 the Supreme Court of Wisconsin *(Brown v Industrial Commission*, 9 Wisconsin [2d] 555) has ruled on causality of a ruptured vertebral disc as follows: "It is immaterial as to whether or not the employee was doing anything unusual at the time" or "that the employee had to prove that his injury was the result of an exertion unusual to the ordinary work. . . ."

AUTHOR'S COMMENT

This decision has been a source of concern to both professions and to the trier of facts, and poses perhaps the most serious medicolegal problem on causality before the commissioners at this time. Many feel it has made admissible a greater number of unjustified back claims. Apparently to avoid a similar position in cardiac claims cases in Wisconsin the term usual or unusual has been avoided in fear that it may, if adopted, induce a rash of heart claim cases. The ruling is unsupported by scientific evidence. Actually medical causal relationship on the basis of chronic (degenerative) diseases and a work-connected event is unlikely since the occurrence is within the natural history (usual course) of the disease. However, if the stress or strain can be clearly shown within a reasonable degree of medical probability to be unusual or excessive for the individual, then medical causal relationship can be considered.

Comments were made on related topics such as the wisdom of increased use of independent medical experts (board certified internists or knowledgeable physicians) whose advice would be con-

sidered by the commissioners. The usefulness of a panel of expert medical witnesses was debated; however, the feasibility of the commissioners' use of independent medical investigation in the form of a panel as a singular cardiac effort was postponed for later and more comprehensive consideration.

The moral and emotional implications of Commission-ordered autopsies, particularly in situations requiring exhuming of the body, was discussed. Autopsies when opposed by the survivors was postponed for later consideration.

A proposal regarding so-called "heart laws" was made, namely that unless expert medical opinion currently supported the 1961 enactment (Wisconsin statute 891.45) creating a presumption that employment is the cause of cardiac disease or disability in firemen with five or more years of service, the enactment should be repealed. Consensus was that this statutory provision concerned municipal employee retirement and benefits and not Workmen's Compensation; therefore, the committee was without jurisdiction on this matter. (The presumption that employment is the cause of cardiac disease is unsupported by medical fact.)

COMMENT

In presenting the model for Rules of Practice, we are emphasizing the medical aspects of the problems involved in adjudicating cardiac Workmen's Compensation claims. These guidelines should be used by all physicians in cardiac claim cases. The standards, however, must be used with full awareness of the medicolegal relationship which exists between the scientific (impairment), social and economic evidence (liability) presented before the court of law. Also important is the concept that employment of a worker under the law implies the acceptance of the whole individual regardless of past or present illness.

In applying the Rules in determining causality, the physician must understand that "the Wisconsin Workmen's Compensation Act defines 'injury' as 'mental or physical harm to an employee caused by accident or disease.'"[10] In the stress and strain category, the Act holds that an accident has occurred '. . . when something unusual, unexpected or undesigned takes place . . . not limited to the application of violence or external force . . . rather it connotes something not within the expectation of the individual.' "[11]

The testifying physician, therefore, must realize that the final legal ruling on causality may not necessarily be based upon the medical determination alone. Still, the law does require that any ruling on causation must be supported by reasonable medical evidence.

Much medicolegal confusion arises because of different interpretations of the term "cause" by law and medicine, particularly in cases involving degenerative (nonoccupational) diseases such as heart disease. Causal relationship to the physician means etiology or specific medical cause (pathological, abnormal function). The attorney, on the other hand, may view as causally related to employment any incident which appears mentally or physically harmful by aggravating a pre-existing condition to the point of producing disability or death.

A man with a perfectly healthy heart will never have an attack, no matter how great the exertion. Pre-existing heart disease must be present to produce a heart attack. Medically the cause (etiology) of arteriosclerotic heart disease (heart attack) is unknown and is unrelated to employment. Most scientists agree that there is no known causal relationship between a heart attack and sleep, rest, or usual activity, the circumstances under which most attacks occur—i.e., within the natural history of the disease process. However, there is evidence to support the view that unusual or severe physical or emotional stress or strain in a very small segment of the coronary disease population may be the inciting factor aggravating or "lighting up" a sudden heart attack. Thus, unusual physical or emotional exertion or strain or stress may for the individual precipitate an attack if clearly above his usual capacity (physical fitness) on or off the job. In this sense, a physician will concede that exertion can medically "cause" an attack if the exertion is work-connected and "arising out of employment," i.e., resulted from an act performed for the employer.

Here again confusion may arise even in a jurisdiction such as Wisconsin which requires heart claim cases to show "physical or emotional stress and strain in excess of that ordinarily required by the normal activity of daily living." (See Advisory Committee Deliberations). The physician who is highly knowledgeable and experienced in cardiovascular areas knows that what is "normal activity" differs with each individual.

Therefore, the doctor in determining the causal relationship of a work-connected effort and a cardiac episode would require scientific evidence that the (caloric energy [oxygen]) expenditure demanded by the work effort was clearly in excess of the *particular individual's* usual level of energy cost on or off the job, and greater than his capacity or state of physical fitness, medically determined, would allow.

It seems essential that the courts accept these distinctions if they hope to retain the primary function of Workmen's Compensation, the protection of the worker. If causality is interpreted too liberally, a few individuals may receive an award, but in the end many more will suffer from a supposedly protective system which will give employers reason to remain wary of hiring a known cardiac in the first place.

In addition to the medicolegal principles embodied in the rules, we must continue to strive to correct some of the problems not covered by these guidelines. One of the most urgent is the improvement of interprofessional relations. There is also a need to better inform medical and legal practitioners of the advances made in medicolegal knowledge pertinent to fair settlement of cardiac claim cases. The

concept of continuing medicolegal education introduced in the undergraduate medical school curriculum (now conducted in cooperation with the Workmen's Compensation administrators in both Wisconsin medical schools) is perhaps the most realistic academic endeavor in establishing a sound basis for an understanding between the professions.

The medical and legal professions and the courts still face a serious challenge in Workmen's Compensation philosophy brought about by the recent shifting socio-economic and demographic changes in a liberal society involving labor, management, and disability insurance.

Can this challenge be met? We think it can. The state of Wisconsin has always offered leadership in this field dating back as far as 1911 when the Workmen's Compensation Act was the first to be effective in the United States. Also, highlights in rehabilitation include the First Wisconsin Conference on Work and Heart Disease,[12] a national meeting sponsored by Marquette University and the Wisconsin Heart Association in 1957; adoption of Workmen's Compensation rules for industrial hearing defects; the State Medical Society's plan for virtually free choice of competent physicians by the injured worker,[13] a cooperative effort between the Society, carriers, and the Commission (Wisconsin Conference Committee) to mediate problems pertaining to medical discrepancies, conduct and practice, and the use of the Wisconsin Interprofessional Code on medicolegal ethics. The State Medical Society also publishes jointly with the Commission, in the January "Bluebook" issue of its JOURNAL, articles on Workmen's Compensation.

The model for Rules of Practice in heart cases if proposed and adopted in the 1969 session would follow precedent already set by a progressive Industrial Commission which followed recommendations of specialists and informed physicians in an effort to adopt formulas to help reduce medicolegal conflicts. Outstanding results have been attained in cases involving industrial loss of vision, hearing, and in the past with silicosis and brucellosis claims.

Our proposal must not be construed as a criticism of the Industrial Commission. Wisconsin examiners have done a good administrative job and have followed the letter of the law. While the number of heart awards made is small (Table 1), there has been a gradual increase over the 10-year period we studied. Any increase must be watched, for it is illustrative of a nationwide liberal trend. The number of heart attacks in this country is increasing and no doubt will continue to increase with a growing population which is living longer. Thus, the

The State Medical Society's CES Foundation

has offered its administrative assistance in acquiring funds for the continuation of a research project related to the problems of the

CARDIAC PATIENT IN INDUSTRY

For the past several years, George A. Hellmuth, M.D. and Elston L. Belknap, M.D. of Milwaukee and Marquette University School of Medicine have directed their attention to this subject and they wish to intensify their research under the direction of the Foundation.

Medical evaluation and placement, as well as reemployment, are matters of economic importance which have not been subjected to concerted research and study.

In cooperation with the Marquette University Law School, Doctors Hellmuth and Belknap also are directing their attention to the attitude of attorneys toward compensation programs and cardiac disabilities.

These studies have been recognized nationally through publication of a series of articles in the JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION. Two such articles were published in 1966; two more are being published in 1967. At the request of WISCONSIN MEDICAL JOURNAL editors, Doctor Hellmuth wrote a brief article in which he combined the major points appearing in the four JAMA articles with particular emphasis on the Wisconsin situation. It appears in adjacent columns.

To conduct further research in this area, the research team has enlisted the Foundation's cooperation. Solicitation of funds from Wisconsin industry has been started.

The research would be supported for the next two years in the following areas:

1. Studies on employment policies regarding the cardiac in industry (primarily in Wisconsin, but applicable to other states).
2. Further study of medicolegal attitudes of attorneys toward Workmen's Compensation in Wisconsin (and how this would apply in other states).
3. Completion of current studies as to attitudes of industrial supervisors toward cardiac workers.
4. Determination as to the usefulness (education, research, and service) of a cardiac work classification unit in rehabilitating cardiac patients and returning them to employment.
5. Preparation of lay information on work and heart disease in industry.

Contributions, which are tax deductible, are being accepted now. A full report of the project's support will be made at a meeting of the Foundation's Board of Trustees later this month.

number of cardiac claims cases under the present system also will continue to grow.

Many physicians are aware of the problem and feel a need to study and improve our present system. Others interested in this area must be responsive to the results of research and to the leadership of the profession (e.g. American Medical Association,[14] American Heart Association[6]). Only the testifying physician can make use of the precise medical knowledge available today. Only by his efforts will the incidence of conflicting medical testimony be reduced significantly.

We respect the opinion of the Advisory Committee that there is no need for adopting cardiac rules "at the present time" presumably because of the small number of yearly compensated cardiac cases. This is true. The statement that cardiac involvement cases "were being satisfactorily handled by the Commission"[9] interpreted in terms of administrative procedures is also true.

Nevertheless, it is impossible to erase the fact that medical testimony under the present conditions is not adequate, that in over 50% of the claims judged to merit awards during the period we studied, the decisions proved medically unjustified.

We are convinced that a problem exists like a weed planted in fertile ground. Unless measures are taken now (no administrative changes in procedure have been made since our study cases 5 years ago), the weed will grow and the Commission may be faced with a more serious problem, perhaps similar to the knotty involvement in which it now finds itself in the litigation of back injury claim cases. Whether 6 or 600 cases are involved annually, the principle is the same. More important than the relative smallness of the 6 or greatness of 600 is the question of how and under what system will 6 or 600 heart attack victims be returned to our working society as productive individuals.

In fact it only requires one misdirected case for evidence to turn to a medically adverse judicial ruling which will affect many cases in the future and create untold employment problems for both worker and management. In view of the inactivity in this area, will society continue to accept these disturbing factors or will a federal program be established? Thus, if cases are not adjudicated properly with the protection afforded by a sound medical formula (e.g. the proposed rules), there is reason for all to be concerned. We wish merely to state that the decision of the Advisory Committee to "defer" the proposed cardiac rules on the basis that cardiac claim cases are being satisfactorily handled by the Commission at this time is difficult for the physician to understand.

The Commission may require more time for study and observation in considering possible future acceptance of the rules. We have been encouraged by the chairman and director of the Industrial Commission of Wisconsin who have commended our efforts to improve communications between the physician, attorney, and commissioner and to better inform the medical profession in the use of a sound medicolegal formula.[9,15] At most the guidelines at this time have provoked discussion by the bar, bench, and board—a necessary step in any medicolegal, educational endeavor.

We were also pleased to observe the increasing use by the Wisconsin commissioners of the pretrial system of conference. This provides an excellent opportunity for the judicial tribunal to evaluate the medical evidence provided by the independent medical witness in an environment free of courtroom stress. We would urge that the pretrial system and reliance on independent (state-selected) expert medical witness (permitted by statute) become standard procedure.[16] Under the adversary system, however, it must be understood that the party desiring cross-examination of the independent witness shall have a legal right to make arrangements for his attendance at the hearing, and that he be duly identified to those in interest and allowed no more than the same privileges given any witness in court.

For these procedures to be truly effective, we must emphasize the necessity that all medical witnesses have access to and use all available clinical evidence and whenever possible have the opportunity to question and examine the patient themselves. The medical witness after all can be only as good as the medical information allows him to be. In this area our examiners have been helpful in seeking and authenticating the circumstances surrounding the work-connected incident.

The model for rules will not solve all Workmen's Compensation problems involving the cardiac case. It does represent an honest attempt to resolve *some* of the serious medical difficulties short of changing the statutes. The application of this document can be useful only as a guide in the sense that informed medicolegal opinion will *usually* or in *most* cases deal fairly and as accurately as the science of medicine will allow.

The ultimate, short of removing degenerative disease claim cases from Workmen's Compensation, is to formulate adequate legislative provisions applicable to the fair settlement of claims. Everyone realizes that to amend a law is a major undertaking frought with claims and counter-claims from many parties, some with vested interest. Thus, the model for cardiac rules as an initial medicolegal rehabilitation endeavor is offered as a physician's guide workable under the Act within the adversary system of the law, and mandatory in principle to the survival of our traditional state system.

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SPECIAL TO THE JOURNAL

WILLIAM BEAUMONT AS A PHYSICIAN

By ESTELLE BRODMAN, Ph.D.
St. Louis, Missouri

MUCH HAS BEEN WRITTEN about William Beaumont and his epoch-making experiments on gastric physiology. Practically every move that he ever made in connection with Alexis St. Martin has been chronicled and studied with care. He also has been considered several times in his capacity as an Army officer, particularly by the more scholarly surgeons in the Army Medical Service. On the other hand, Beaumont's day-to-day practice as a physician has received almost no consideration, and it is therefore on this subject that I propose to talk tonight.

For some time now, I have felt that Beaumont was typical of his time and place in the historical development of American medical practice, and that to study what he did day in and day out is to learn what the large majority of medical practitioners throughout the country were probably also doing. He is thus the "average" physician, whose life is both interesting in itself and valuable as a mirror of the total milieu around him.

At the beginning of the 19th century, there were only two medical schools in the United States: one in Philadelphia (to become the University of Pennsylvania) and the other in New York (to become Columbia University). Most medical men, by a wide majority, were trained not in these formal schools, but as apprentices to other physicians in their localities. The usual practice was for the student to be attached to his preceptor for three years after a common-school education that might include additional study in Latin, Greek, or mathematics with a local clergyman. During the years that the pupil stayed with his master, he lived in the master's household, read his medical and other books (if any were available), and attended to the less glamorous jobs of a doctor's practice, such as cleaning out the office, compounding the prescriptions, taking care of the horse, running errands, and (as he grew more proficient) treating the simpler cases, such as incising and draining an abscess, pulling a tooth, or bandaging a limb.[1] Some of our most famous American physicians were educated in this fashion: I need only mention Daniel Drake and Joseph Nash MacDowell to show that such a system was not necessarily a poor one, if the preceptor was good and his library well stocked and available. (David Hosack in New York City, for example, had over a hundred students during his career, and he set aside regular periods for them to read, after which he quizzed them on what they had studied.)[2] More affluent apprentice-trained physicians often continued their education in Europe: they went to Leyden, Edinburgh, or the London hospitals, following it by a grand tour of the continent before returning to the colonies. Always, however, their fundamental grounding was from their preceptor–student relationship. (Parenthetically, it is interesting to note that many medical schools in the last few decades are returning to a system of preceptorships for medical students, to bring them back to the clinical phases of medicine.)

In all of this, William Beaumont was typical of his time. He finished the common schooling in his native Connecticut, then followed his older brother to Champlain, Vermont, where he taught school, kept a store, and did other odd jobs. He finally decided to enter medicine—why, we do not know; his early letters in the Yale University collection do not give details (except for a small fragment which says merely he will do as well as he can)—and he read the medical books of Dr. Seth Pomeroy before apprenticing himself to a nearby physician, Dr. Benjamin Chandler of St. Albans, Vermont. His notebooks and "common book" of quotations from that period are in our collection at Washington University, and have been edited and published by Dr. Genevieve Miller, now at Western Reserve University. Beaumont finished his formal study in 1812, was examined and duly licensed to practice medicine and surgery by the Third Medical Society of Vermont in June of that year, after which he was ready for actual practice.

As is well known, Beaumont was not too successful as a practitioner at first and finally decided to enter the Army as a Surgeon's Mate during the War of 1812. He also spent a longer period in the regular Army, from 1820 to 1829. His medical knowledge, gained from his preceptorship, was aided and added to by his experience as an Army surgeon.

From 1815 to 1820, Beaumont practiced privately in Plattsburgh, New York. There he kept an account of interesting cases encountered,[3] and from it one can obtain a fairly good picture of normal frontier life. As might be expected, traumatic injuries and fevers lead all the causes of illness, with an occasional case of typhoid fever or rabies to add piquancy to the routine work.

Doctor Brodman is Librarian and Professor of Medical History, Washington University School of Medicine.

Presented at a Seminar on William Beaumont by the La Crosse County Society for the History of Medicine, during the 125th Anniversary Meeting of the State Medical Society, La Crosse, May 10, 1966.

Many of the fevers were malarial in origin—the ubiquitous "ague" of the pioneers, and over and over again Beaumont treated it with calomel and ipecac in huge doses (in the first case recorded, he gave 8 gr calomel and 10 gr ipecac in hourly doses; repeated draughts of gruel and acidulated drinks, and vinegar rubs to the head and feet. He also extracted 12 oz of blood. As the patient gradually became better, he was fed gruel and arrowroot pudding, and even given the arrowroot by injection, alternated with rice or "Sulph-Soda" [Sodium Sulphate] in the injectant.) You will be happy to know that the particular patient whose case history I am recounting had a "perfect and distinct crisis" on the seventh day, that the profuse sweat lasted for several hours, "after which time he continued to convalesce uninterruptidly."

Another patient made an even speedier recovery. He was "violently attacked with an acute pain in the stomach, extending across the chest, producing a dispnoe(sic) almost to suffocation, cold extremities and rigors. Tongue clean. Some nausea, etc., and a violent pain in the head across the forehead." If, as I believe, the man was suffering from some form of cardiovascular attack (perhaps a myocardial infarction), the treatment given by Beaumont was certainly opportune. The first thing he did was to bleed the man of 12 ounces of blood, then he ordered hot applications to his breast and pericordium. After that, his treatment was heroic, I would say. The patient was given 15 gr of calomel—without which no frontier physician apparently considered his duty discharged—but in spite of it, the man was up and about the house the next day as if nothing had happened. A similar case is recorded later, which took longer to get over; this patient not only was bled and purged, but he was given ether to drink and laudanum for his pain, and then made to drink copious amounts of ginger tea.

Two cases of "spotted fever" in children within a few days of each other are detailed in the journal. (I believe this was measles, not typhus, and the spots may have been Koplik's spots.) The patients, one eight years old and the other less than one year, were purged, bled, blistered, and placed in salt baths. The older child died, but the younger, after a stormy course, finally recovered. Whether the mother, who was directed by Beaumont to bathe the child every three hours and to give different medicines on a complicated and alternating schedule, ever recovered from the rigor of nursing the infant, we are not told.

More unusual accidents happened in Plattsburgh, too. On Aug. 8, 1819, Mrs. Wheeler, wife of Mr. Zeb Wheeler, was bitten by a cat supposed to be rabid. The Wheelers lived four miles from town and it took Doctor Beaumont between one and one and a half hours to reach them. He immediately excised the skin and part of the flesh of the right foot and then dressed the wound with *Alisma plantago* (a diuretic "of doubtful efficacy" according to a German writer of the period[4]), with orders to keep the dressing moistened with vinegar and salt. In spite of this, the wound became inflamed and swollen and Mrs. Wheeler ran a temperature some 3 to 4 days after the accident. An emetic was prescribed for nausea, and a charcoal and yeast poultice applied to the foot—the traditional treatment for absorbing secretions. A purulent discharge and healthy granulations (the laudable pus syndrome) soon appeared, and it seemed by the end of the fourth week that all was well. On the tenth of September, however, poor Mrs. Wheeler began to show symptoms of a generalized infection—the wound was discolored and discharging foul-smelling pus, she had tingling pains up the side of her foot toward her groin, a violent headache, confusion of intellect, and partial loss of vision. Beaumont decided she had hydrophobia and felt that only strong remedies were likely to have an effect. He dosed her with massive amounts of calomel and a decoction of *Scutellaria latiflorae* (one of the mints used as a tonic and antispasmodic), then changed the prescription to alternate doses of 2 gr of calomel, ipecac, and nitre every six hours, with drinks of dilute ammoniated vinegar in between. He also blistered the ankle and placed a second blister on the back of her neck; used carbon dressings on the wound, and had her sponged with vinegar.

The patient continued on an up-and-down course for another six weeks, until on Oct. 20, 1819, Beaumont could write of her, "Perfectly recovered and enjoys as good health and spirits as usual."

We have, so far, discussed a typical case of fever treated by Beaumont, one of suspected rabies followed by severe gangrenous infection, and a medical case of cardiovascular origin, and now we come to a patient with a severe traumatic injury.

Plattsburgh, New York, where Beaumont was practicing, was one of the Army's chain of outposts to protect the infant United States from the Canadians, Indian and white, who had fought the Americans so savagely in the War of 1812. One Sept. 18, 1819, Beaumont was called in consultation by the Army's Surgeon's Mate stationed in Plattsburgh, Dr. L. Foot, who remained a friend of Beaumont's for many years afterwards. On the previous evening a soldier had (I quote Beaumont's account) "the temerity to touch of (sic) the charge of a rock in blasting by putting fire immediately in the priming, in consequence of which he received the blast into the side and back of his head and neck, fracturing, with a small stone, the occiput at its inferior extremity, depressing a portion an inch long and three-fourths of an inch wide at the upper edge and ranging in a triangular shape downwards, even to the Foramen magnum and immediately over the medulla oblongata." Other portions of the skull were also damaged. Trephining was performed the next day after symptoms of compression were noted; the spicules of bone and gravel were removed from the wound, and the head dressed with dry compresses of lint in an effort to keep the medullary tissue

from protruding from the skull. A carbon and yeast poultice was also applied to absorb any secretions, and then the poor soldier was bled 12 to 16 oz., as well as being given a saline cathartic.

For some days he progressed well, but a week later the patient was suddenly attacked with a violent pain in the head and became delirious, while the wound began discharging foul-smelling pus. The dressing dropped off and a portion of the medullary substance "the size of a butternut," says Beaumont, protruded from the wound. At this point, Beaumont noted his opinion that if the substance protruding from the fracture sloughed off, the patient would undoubtedly die "unless he can live with the half of the substance of the medulla oblongata at its origin carried away by mortification." The prophecy was only too true; the soldier died on October 2, "with the whole mass of the cerebellum in a state of disease and mortification."

Trephining with the subsequent death of the patient was to be present once more in the professional life of Beaumont. In 1840, 21 years later, Beaumont was called into consultation in St. Louis in the case of a man (Andrew Jackson Davis) who had been felled by a political opponent (William P. Darnes). Darnes had used an iron cane to beat the victim into insensibility. Beaumont recommended trephining and performed the operation. Davis died six days later and Darnes was brought to trial for murder. The defense thereupon attempted to prove that Davis' death was due not to Darnes' blows but to Beaumont's surgery, and it is sad to relate that many physicians in St. Louis, who had quarreled frequently with Beaumont, testified against him. (I can understand his contemporaries' views of Beaumont; he was not a man to suffer fools gladly and he thought many of his colleagues fools.) Beaumont spent the next decade or so attempting to vindicate his character and his professional abilities. Never an easy man with whom to get along, after the Darnes–Davis case, Beaumont was more bitter, more sure everyone was against him, and more outspoken of his contempt for those about him than ever before.

I now come, finally, to cholera.

Some idea of the swiftness with which cholera strikes can be found in Boccaccio's *Decammeron*, who says of the plague what was equally true of cholera, "Many dined with their friends in this world and supped with their ancestors in the next." Heinrich Heine has left us a graphic account of a Parisian outbreak of 1831. On March 20, a masked ball was in progress. Suddenly, one of the harlequins collapsed, his face became violet-blue and his limbs cold. He died right there at the ball. Within a few hours, wagon loads of people were being taken to the hospital, L'Hotel Dieu, where they died that night and were buried in mass graves, still in their ball costumes.

Cholera first made its appearance in the new world in 1832, arriving from Europe in the immigrant ships full of people fleeing the potato famine in Ireland and a crop failure in Germany. The epidemic reached the United States from two routes, north and south: immigrants landing at Montreal went up the St. Lawrence River to the Great Lakes and down the Great Lakes to the Mississippi as far as St. Louis and farther. Others also using the northern route left ship at Montreal or Quebec and proceeded overland to upstate New York and thence to the Northwest Territory, including what is now Ohio and Michigan. The southern route for the introduction of cholera was via New Orleans, to which many of the immigrant ships from Germany were bound, and thence up the Mississippi to St. Louis, which thus received the infection from both directions.

Beaumont had been involved in cholera epidemics as an Army officer in Wisconsin during the Black Hawk War of 1832. This was the engagement in which General Winfield Scott was commanding officer, and General Scott had a theory that cholera, which was slaying his men more effectively than the Indians, was caused by drunkenness. He therefore issued an order that any soldier who appeared drunk in camp was to be placed on the grave detail to bury the cholera victims and to see for himself the end to which has profligate life was leading. While Beaumont appears not to have shared this view of the cause of the disease, he certainly had much experience with it in the Army, from which he came away with a strong respect for it.

When cholera struck St. Louis in 1849, the city had a population of 63,471. The epidemic resulted in 4,317 deaths, for a mortality rate of 68 per 1000. (In contrast, New Orleans' epidemic that same year only yielded a mortality of 30.47 per 1000.)

Cholera started on emigrant ships in New Orleans in December 1848, and was carried up the Mississippi and along the Ohio and Missouri River valleys within a few weeks. One traveler wrote:

> "I left New Orleans on the 26th January on Steamboat Boonslick for St. Louis and in eight days arrived at the mouth of the Ohio. . . . We arrived at St. Louis I believe on the 13 February. There was two cases [of cholera] on board the Boonslick one the succeeding night and another the next day after we left Orleans one died (he was one of the deck hands belonging to the Boat he was attacked about 10 o'clock in the evening and died before morning.) The other who recovered was a deck passenger. . . ."[5]

During the last week in December 1848, several boats with cholera cases came to St. Louis from New Orleans, perhaps the worst being the AMARANTH, which had 30 cases when it dropped anchor on December 28. On Jan. 23, 1849, two other ships docked; one with 46 cases aboard and 6 deaths, the other with 26 cases and 4 deaths. For the next two weeks, several other such ships arrived. On January 9, the newspapers reported the first cases of cholera within the city, 2 deaths among them, attributed by the editor to eating spoiled cabbage. From now on

the epidemic began to grow until there were 600 deaths per week in June. No one quarantined the passengers, or separated the sick from the well; panic took over, until finally the citizens were aroused to do something about the matter. A Board of Health was named, consisting of one physician to give advice and a group of prominent citizens who made recommendations to the city government, which included the disinfection of backyards and damp places with chloride of lime.

The disinfection didn't stop the spread of the disease, which got progressively worse, as more boats came up the Mississippi and as more immigrants came along in their Conestoga wagons for the gold fields of California and for the Oregon Trail. It got so bad that the Circuit Court finally had to adjourn for three weeks in May because there weren't enough well jurors for trials. Deaths were running about 30 per week, when suddenly, on May 17, a devastating fire burned out almost all of the city near the waterfront. This disinfected the area much more effectively than the chloride of lime, and for a while it looked as if the epidemic might have been checked—much as the Great Fire of London in 1664 did away with the plague.

By the ninth of June, however, the deaths from cholera were back again to what they had been before the great fire. Citizens denounced the Board of Health for inaction and a quarantine was finally insisted on. A citizen group took over the government of the city as a "Committee of Public Health" with almost dictatorial powers, and the City Council voted them $50,000 to use as was necessary, as well as making it a punishable offense not to obey their rules.

The Committee set up hospitals in each ward, provided for thorough cleansing of the entire city (including urning sulphur, tar, and stone coal), appointed a day for fasting and prayer—and finally got around to setting up a quarantine station on Arsenal Island in the River. This was opened on July 3, and by July 10 more than 300 people were there. From then on the mortality (which had climbed to 145 per day) steadily declined, and the epidemic was virtually over by September of that year.

Beaumont was in the forefront of those who were treating the cholera victims. His greater experience with the disease than his colleagues, due to his work with the Army during the Black Hawk War epidemic, led him to be called in for advice far and near. In a letter in our files from that period, he outlines the treatment he prefers, and I should like to end my lengthy talk by reading parts of his letter. As I do so, you will see that Beaumont uses the accepted remedies of the time—friction to increase circulation, opium and ether as muscle relaxants, and the ubiquitous calomel, cupping, and bleeding to rid the body of the morbific matter. Alkaline drinks are also prescribed, but they are distinctly less important to Beaumont than the other items. The small amount of success which Beaumont had with this treatment is reflected in the nonmedical remarks he makes on the disease:

"Your friend Noonan of [?] requesting to know my treatment of that scourge of St. Louis *the cholera* was a few days since rec'd and kindly appreciated, and I take this first leisure moment to comply with the human and benevolent requests of so highly esteemed friends as yourself and the Doctors Wolcott and Dousman—hoping and believing that an equally or more efficient treatment will have been learned-developed should the fell disease have made its appearance in your community ere this reaches you.

"My most successful treatment in the clearly defined cholera attacks has been in the incipient stages, simple diarrhoea and copious thin fluid discharges from the bowels, sick stomach, vomiting with cold clammy perspiration. I generally commence by giving of the following combination

R Tr. valerian ammoniated

Tr. opii ā ā
Tr. Camphor)
Sulphc Ether)
Ess Peppermint—

from 40 to 60 drops in the best brandy and sugar every 2 hours or often or after every fluid dejection, applying the sinapism to the stomach and the extremities and hot stimulating friction of alcohol and capsicum, dry coarse cloth or brush etc over the whole surface, to be repeated and [in] force and frequency on the first occasion of cramps and pain in abdominal viscera. Should not these effectively check the severity of the symptoms and controll[sic] or supress the morbid discharges and sensations in a few hours—I come in with the calomel opium camphor and capsicum or quassiae [?] in free and liberal doses—either 20 grain doses of cal 1½ of opium 3 of camphor and 2 of capsicum or quassiae [?]—the last where the internal type prevails or sharply indicated-repeated at appropriate intervals when the stomach will tolerate the dose—or I give in smaller broken doses of 5 gr. Cal 1 opium 2 camphor every 2 hours or after every dejection for 12 or 16 hours or till the disturbance be quieted and the secretion essentially changed to more consistent tar like discharges—which occurences [? ?] seldom fails to be experienced and the disease subdued.

"The free use of alkaline drinks is very useful in all stages of the disease—I advise the [? ?] solution of super carb soda or carb ammon in oft repeated [?] draughts and vesications over stomach. Where nausea and great heat and pain in the gastric cavity are complained of—To obviate the tendency to cerebral and thoracic congestion I advise cupping [?] to the chest, abdomen and whole spinal column, and in full plethoric habits and robust constitutions if called before the congestions has become complete and collapse evident I bleed freely at the arm or leech and blister the back of the head, neck, and dorsal spine with [?] facility

success—But if the subject has passed the verge into the cold blue stage of collapse no medical means, skill or human effort seems entirely impotent of relief [sic]. Relatives and friends shrink with sorrowful emotions, and doctors stand aghast in mute astonishment and mortification at the resistless rapidity of a disease so little understood and over which their most profound skill and judgment and professional efforts can have no salutary influence or effect.—a disease which I conceive to be *sui generis* of atmospheric origin, sent by God over the face of the earth to scourge mankind—Test the wisdom and ability of the most learned and experienced of medical faculty of all conditions and to admonish us, minor masters of our Profession, of our almost total ignorance of all diseases or the best means of cure.

"Thus you have my general treatment Though not *always* successful in saving life or rescuing from the ravages of this strange and direful epidemic, it has been as successful as most others in this city and vicinity. . . .

"May God avert the fell disease from your community and [?] spare you all individually and Professionally from the agonizing pain, distress, and consternation of its visitation.

". . . My self and family all well. The epidemic just subsiding affording a little respite from incessant Profl ?[claims?]"

In this, as in all other matters, we see Beaumont as the typical physician of his time, faced with medical problems whose cause he did not understand and whose treatment thus had to be empirical, but always brave, always sympathetic, always active in his attempt at the alleviation of disease. Not for him was the doctrine of the *Vis medactrix naturae;* his was the active and determined fight against death and disease—and if it may not have helped the patient medically, it probably soothed him and those about him to think that "everything possible was being done" for the sick man.

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FESTSCHRIFT HONORING

WE NEED his example more than he needs our good wishes for the coming years. This is my personal feeling for Harry Beckman who has contributed so much to the development of Wisconsin physicians and the sciences of medicine and pharmacology.—Harold F. Hardman, M.D., Ph.D., in WISCONSIN MEDICAL JOURNAL, March 1962.

THROUGH 20 years of research at Marquette university, a dynamic little man has made tremendous contributions to the world's knowledge of blood diseases. . . . He is Dr. Armand J. Quick . . . recognized as one of the world's authorities on diseases which cause bleeding.—MILWAUKEE JOURNAL, May 16, 1954.

Harry Beckman, M.D.

Armand J. Quick, M.D.

THE STATE OF WISCONSIN has been especially fortunate to have within its boundaries two such distinguished medical scientists and disciplined physicians as Doctors Harry Beckman and Armand J. Quick of Milwaukee. It is a distinct privilege to recognize them for their many years of dedicated research and teaching at Marquette University School of Medicine. Although each has excelled in a separate field—Doctor Beckman in pharmacology, Doctor Quick in biochemistry—it is appropriate to identify them as an illustrious pair who has had tremendous influence in the development and progress of Marquette University.

These special issues—July and August—contain a number of scientific articles written by several of their students and colleagues at the request of the editors. Letters of tribute, their bibliographies, and significant honors also are recorded in appreciation of the high esteem so deserving to these two men.

The Editors and Editorial Board wish to thank all those who assisted in the preparation of these issues, and express sincere best wishes to Doctors Beckman and Quick.

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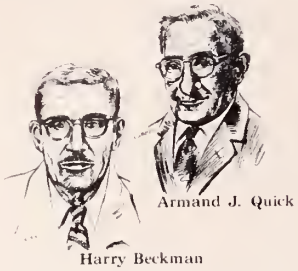

WISCONSIN MEDICAL JOURNAL
JULY/AUGUST 1967

The Action of Heparin as an Anticoagulant

By J. N. SHANBERGE, M.D., Evanston, Illinois

■ HEPARIN, a powerful and efficient anticoagulant, was discovered over 60 years ago[1] and has been used clinically since 1935.[2] Yet, its specific action as an anticoagulant has not been definitely determined. In 1918, Howell and Holt[3] claimed that the new anticoagulant agent acted by (1) preventing the conversion of prothrombin to thrombin, (2) converting the precursor of antithrombin to an active form, and (3) antagonizing the action of thromboplastin. In 1936, Quick[4] stated that, by itself, heparin is not antithrombin but exerts its anticoagulant activity only in conjunction with a constituent of plasma which he believed to be albumin. He also questioned that heparin is antithromboplastin, stating that increasing the concentration of thromboplastin actually overcomes the inhibitory effect of heparin by increasing the production of thrombin which in turn then overcomes the inhibition.

As observed in the test tube, the progress of blood coagulation is a relatively slow process until the very first appearance of thrombin, whereon there is a rapid and great leap forward toward the formation of the fibrin clot. That thrombin plays a role as an autocatalytic agent in accelerating its own formation has been maintained by Quick for many years, although his concept as to the site of its action has changed periodically. At first, he thought that thrombin was important in labilizing platelets so that a platelet factor could react with thromboplastinogen (Factor VIII) to bring about the production of the prothrombin convertor, "thromboplastin."[5] Later, he felt that thrombin directly activated the thromboplastinogen.[6] In 1957, recognizing the discovery of Factors IX and XI, he now indicated that the thrombin might act on any one of the components of the "thromboplastinogen complex," that is, VIII, IX or XI.[7] Most recently, Quick has indicated that it is the activation of "contact factor" which is mitigated through the catalytic action of thrombin.[8]

The concept that thrombin is important in the activation of certain coagulation factors has been stated by other investigators.[9-13] It has been claimed that thrombin primarily activates Factors VIII and V, although this has not been completely accepted.[14,15] The autocatalytic action of thrombin in the progress of blood coagulation has been ignored in the recent cascade and waterfall schemata of blood coagulation as advanced by Macfarlane[16] and Davie and Ratnoff.[17] What these authors forgot is that in most waterfalls or cataracts there is a "spray phenomenon" whereby the downrushing stream is partially replenished by the spray of mist produced at the end. In the same way, thrombin, once produced, reenters the stream of coagulation as a catalyst to accelerate the progress of reaction.

In recent years, my coworkers and I have interested ourselves in trying to find more precisely how heparin acts as an anticoagulant. In 1958[18] and, in more detail, in 1959,[19] we described the inhibitory effect of heparin on the formation of the clot promoting activity formed in the thromboplastin generation test confirming the observations of Biggs, Macfarlane and Douglas,[20] MacMillan and Brown,[21] and Douglas.[22] From our stud-

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Much of the work reported in this paper was supported by grants from the USPHS–NIH, the Chicago and Illinois Heart Associations and the Thomas J. Dee and George C. Moody Memorial Research Funds of Evanston Hospital.

ies it was determined that heparin interferes with the formation of this clot-promoting activity by inhibiting the activation of Factor IX. Moreover, at that time we speculated that thrombin was necessary in the activation of PTC (Factor IX) and that heparin interferes with this activation by being antithrombin. Previously, we had found that the antiheparin, protamine, inhibits thromboplastin generation by similarly interfering with the activation of Factor IX.[23] Subsequently, we found the same for hexadimethrine bromide (Polybrene), another antiheparin.[24] O'Brien[25] and Greig[26] also found that heparin inhibits Factor IX activation but they believed that this is brought about by a direct action of heparin on Factor IX.

More recently, we confirmed the observations of Ratnoff and Davie[27] that Factor IX is activated by activated Factor XI.[28] In addition, we found that this activation is accelerated or enhanced by the presence of thrombin and for this reason is inhibited by heparin. The heparin antagonist protamine was found to inhibit this reaction by acting directly on the activated Factor XI, whereas hexadimethrine bromide, another antiheparin, interferes with the activation of Factor IX by combining directly with the Factor IX precursor. More recent work has shown that in both the intrinsic and extrinsic systems of prothrombin conversion heparin interferes with Factor X activation which is also accelerated in the presence of thrombin and that the antiheparins, protamine and hexadimethrine bromide, also interfere with X activation but do so by acting directly on the Factor X.[29] Similarly, we have found that activation of Factor XIII (fibrin stabilizing factor) which is dependent on thrombin is also inhibited by heparin. Thus, a clot formed in heparinized blood is not a stable clot but can be dissolved in 5M urea or monochloracetic acid as is a clot formed with thrombin and purified fibrinogen.[30] The heparin antagonists also interfere with this reaction most likely by acting on the fibrin polymer, object of Factor XIII action.

In all of the above, heparin does not act directly against thrombin alone but does so together with its cofactor.[31] Other studies in our laboratory utilizing electrophoresis and column chromatography have now shown that the heparin cofactor and the naturally occurring antithrombin, the antithrombin III, are distinct, separable entities.[32,33] The cofactor is an alpha-2 globulin whereas antithrombin is an alpha-1 globulin.

When thrombin acts as an enzyme, it first forms a complex with its substrate. This complexing is inhibited through a competitive complexing of thrombin by the cofactor and heparin, a polyelectrolyte with a strong negative charge. This inactivation of thrombin is an immediate reaction. The action of the naturally occurring antithrombin is slower and progressive, resulting in destruction of thrombin activity.

That heparin plus its cofactor only inactivates thrombin is certain inasmuch as the complexes formed between heparin plus cofactor and thrombin are dissociable and can be broken by the greater affinity of heparin for its polyelectrolyte antagonists such as protamine and hexadimethrine bromide so that the bound thrombin activity can be liberated. However, in plasma, after a longer period of inactivation by heparin plus cofactor, less thrombin activity can be restored with the heparin antagonists since part or all of the thrombin may have been destroyed by the superimposed action of the antithrombin III.[33]

The antiheparins, such as hexadimethrine bromide and protamine which are polyelectrolytes with strong positive charges, act on the opposite side of the reaction, that is, by complexing the substrates. Hexadimethrine bromide acts as an anticoagulant by complexing Factors IX and X, the "substrates" of thrombin just as protamine, another antiheparin, forms a complex with Factor XI or precipitates fibrinogen. The interference of heparin as well as protamine in the thrombin–fibrinogen reaction has already been demonstrated by Amann and Werle[34] and have been described in other enzyme substrate reactions.[35]

From our work with heparin, it would seem that thrombin accelerates not only the activation of Factor IX which in turn activates Factor VIII, but also the activation of Factor X which in turn activates Factor V. Thus, it is apparent that factors VIII and V are only indirectly activated by thrombin and that this would explain the observations of those who believe that Factors VIII and V are directly activated by thrombin.

In Figure 1 is a schematic representation of blood coagulation in vitro indicating the various points of thrombin action as well as the sites of inhibition by heparin, protamine and hexadimethrine bromide.

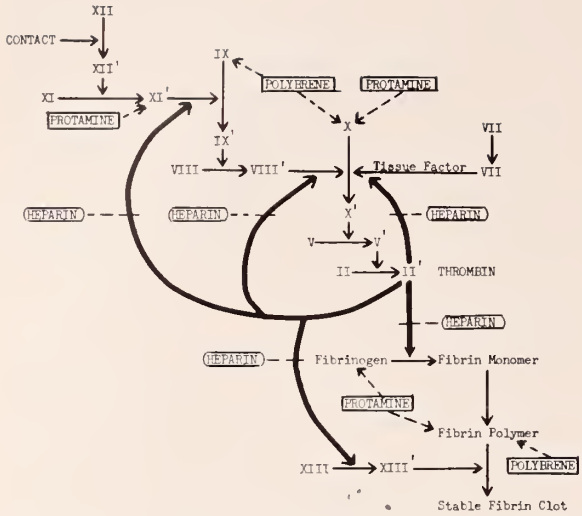

Fig. 1—Schematic representation of the progression of blood coagulation illustrating the sites of thrombin action as well as the points of inhibition by heparin, protamine and Polybrene. For the sake of simplicity, reactions requiring or being influenced by calcium and phospholipid have not been included. The formation of the intrinsic prothrombin convertor is presented on the left and that of the extrinsic prothrombin convertor on the right.

SUMMARY

Heparin, together with its cofactor, an alpha-2 globulin, acts as an anticoagulant in only one way, as a thrombin antagonist, not only in preventing the conversion of fibrinogen to fibrin but also in delaying or preventing the autocatalytic effect of thrombin in accelerating the progress of coagulation through the activation of Factors IX and X.

Heparin also prevents the formation of a stable fibrin clot by inhibiting the activation of the fibrin stabilizing factor (Factor XIII) which is also dependent on thrombin.

The cofactor of heparin is distinct and can be separated from the naturally occurring progressive antithrombin (antithrombin III) of blood.

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Hypochromic Anemia with Increased Iron Stores

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This little article is a small expression of the respect and affection the authors hold for their esteemed teachers Drs. Armand J. Quick and Harry Beckman. It is a privilege to have received part of one's education in the hands of such dedicated scientists and educators.

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■ DEFECTIVE HEMOGLOBIN synthesis results in the distribution of inadequate amounts of hemoglobin to erythrocytes. If red blood cell stroma is produced at a nearly normal rate, resultant erythrocytes are hypochromic. The most frequent clinical cause of hypochromic anemia is iron deficiency where insufficient iron is available to saturate protoporphyrin groups to form heme. However, defects in hemoglobin synthesis may occur for reasons other than iron deficiency. This may also result in hypochromic erythrocytes resembling those of iron-deficiency anemia. Heme synthesis may be defective because iron is not incorporated into hemoglobin efficiently (sideroblastic anemia), or disturbances in the early stages of heme synthesis (pyridoxine responsive anemia; lead intoxication), or deficiency in production of the polypeptide chains of globin (thalassemia). Because each of these disorders may be confused with iron deficiency, afflicted patients are frequently treated with iron needlessly, and often to their detriment. The purpose of this paper is to call attention to several examples of hypochromic anemia where iron deficiency was not present, and show how the correct diagnosis could have been made earlier using comparatively simple laboratory procedures.

CASE REPORTS

Case 1—Thalassemia Minor. A 24-year old Caucasian woman, (Patient 1, Table 1) was seen in November 1966, in the third month of pregnancy. Her chief complaint was chronic fatigue. She had been treated intermittently for anemia since age six with both oral and parenteral iron, without benefit. Her married name obscured the fact of her Italian extraction. Her mother and sisters were also anemic and did not respond to treatment with iron.

Physical examination revealed a pale, thin young woman; the splenic tip was palpable 1 cm below the costal margin. The remainder of the examination was normal. Her hemoglobin level was 10 gm/100 ml; hemotocrit reading, 33%; red blood cell count (RBC), 4,830,000/cu mm; reticulocyte count, 3.4%. The mean corpuscular volume (MCV) was 69 cu μ; mean corpuscular hemoglobin (MCH), 21 $\mu\mu$g; and mean corpuscular hemoglobin concentration (MCHC), 31%. Erythrocyte morphology was abnormal showing anisocytosis, poikilocytosis, hypochromia, and elliptocytes. Serum iron 190 μg%, total iron-binding capacity, 294 μg%. Hemoglobin electrophoresis on cellulose acetate at pH 8.6 revealed HbA_1 92.4%, HbA_2 6.7%. The alkali-resistant hemoglobin was 0.9%. Bone marrow examination disclosed normal distribution of cells with increased deposition of iron.

COMMENT

Although iron deficiency is the most likely cause of hypochromic anemia in a pregnant young woman, this patient's history, physical, and laboratory findings made this diagnosis suspect. These were: her Italian ancestry and family history of anemia, history of anemia since childhood without response to iron, splenomegaly, erythrocyte morphology, and high serum iron. A bone marrow

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TABLE 1

Patient	Hgb.	Hct.	RBC	MCV	MCH	MCHC	Retic.	RBC Morphology	Hgb. Electrophoresis	Bone Marrow
1	10.0	33	4.83	69	21	31	3.4%	Anisocytosis Poikilocytosis Hypochromia Elliptocytes	Hgb A^2 6.7%	Increased iron
2	4.7	15	1.69	88	27	31	0.4	Hypochromia Microcytes Macrocytes	Normal	Increased iron Sideroblasts
3	7.7	27	3.07	88	25	29	0.8	Anisocytosis Poikilocytosis Hypochromia	Normal	Increased iron
4	5.8	23	3.46	66	15	25	0.7	Anisocytosis Poikilocytosis Hypochromia	Normal	Ringed Sideroblasts
5	3.9	17	3.09	55	12	23	1.3	Anisocytosis Poikilocytosis Hypochromia	Normal	Ringed Sideroblasts

smear stained for iron with Prussian Blue revealed many iron particles, ruling out iron deficiency. Hemoglobin electrophoresis demonstrated increased concentration of the minor component, hemoglobin A_2. This is diagnostic of classical thalassemia trait.

Case 2—Primary Acquired Sideroblastic Anemia. A 25-year old Caucasian woman (Patient 2, Table 1) had a history of anemia from age 13 treated intermittently with iron and "liver shots." At age 18 she developed dyspnea, cardiomegaly, and severe anemia requiring three to four blood transfusions per month. A course of prednisone and testosterone was without benefit. Family history was negative except for one sister who was anemic. She was not available for study.

The patient was admitted to the hospital for the first time in 1963, because of severe anemia and jaundice. Physical examination revealed a pale dyspneic young woman with a striking grayish-green skin color. She had a hemic heart murmur. Her liver was palpable 8 cm below the right costal margin and her spleen 4 cm below the left costal margin.

Laboratory investigation disclosed the following values: hemoglobin, 4.7 gm/100 ml; hematocrit, 15%; RBC, 1,690,000/cu mm; MCV, 88 cu μ; MCH, 27 $\mu\mu$g; MCHC, 31%; reticulocyte count, 0.4%; platelet count, 200,000/cu mm; WBC, 5,000/ cu mm, with a normal differential. The peripheral blood smear revealed moderate hypochromia with microcytes and macrocytes. There appeared to be a double cell population probably related to recent transfusions. Serum bilirubin was 10.4 mg/100 ml of which 5.1 mg was direct-acting; alkaline phosphatase, 10.0 Bessie Lowrie units; serum glutamic oxaloacetic transaminase, 109 units; preparation for lupus erythematosus cells, negative; serum iron, 329 μg%; total iron-binding capacity, 425 μg%; fecal urobilinogen 1,864 mg in 24 hours. Bone marrow aspiration showed all marrow elements increased in number. Iron stores were markedly increased and many sideroblasts were seen. Hemoglobin electrophoresis was normal. The plasma clearance of injected Fe^{59} was accelerated, half-life 78 minutes, but the appearance of the isotope in the erythrocytes markedly delayed; only 5.8% of the administered dose was incorporated in 11 days. Survival of Cr^{51} labeled autologous red cells was 24 days with no increased uptake over the spleen. Liver biopsy showed mild portal cirrhosis and marked deposition of hemosiderin in Kupffer's cells.

The patient's jaundice cleared after three weeks hospitalization. A prolonged course of pyridoxine, 150 mg per day, and desferrioxamine, 1,500 mg daily, produced no clinical or hematologic improvement. Over the ensuing two years transfusion requirement remained 2 to 3 units per month. In 1964, she developed episodes of paroxysmal atrial fibrillation and intractable congestive heart failure. In 1965, she entered a hospital in another state and died. Autopsy findings are not known to us.

COMMENT

This woman appears to represent the idiopathic form of acquired sideroblastic anemia. She developed many complications of iron overload; i.e., hemosiderosis, cirrhosis, and myocardial disease. The findings characteristic of sideroblastic anemia included: (1) hypochromic red cells, (2) increased marrow iron stores and sideroblasts, (3) rapid plasma clearance but delayed red cell appearance of Fe^{59}, and (4) markedly increased fecal urobilinogen with a normal or slightly shortened Cr^{51} survival.[1]

In this patient, as well as the others, increased marrow iron stores excluded the diagnosis of iron-deficiency anemia. In this way, needless and possibly harmful iron therapy may be avoided.

Case 3—Pyridoxine-Responsive Anemia, Probably Secondary to Isoniazid (INH). This 67-year old man (Patient 3, Table 1) had a history of silicotuberculosis since 1933. He was hospitalized at a sanitarium from 1962 to 1963 with far-advanced, active tuber-

culosis and severe pulmonary emphysema. In February 1963, he developed neuropathy attributed to INH toxicity, and he was started on 150 mg per day of pyridoxine. His hemoglobin level at the time was 10.4 gm/100 ml and three weeks later was 15.0 gm. The association of the hemoglobin rise and pyridoxine therapy was not recognized clinically, and he was discharged on INH, 300 mg daily; PAS, 12 gm daily, but no pyridoxine. He was admitted to the hospital in October 1963 with congestive heart failure and anemia. His hemoglobin level was 7.5 gm/100 ml and hematocrit reading, 29%. Many hypochromic microcytic red cells were noted on the peripheral blood smear. No history of blood loss was obtained, stool examination for blood was negative, and there was no response to oral iron therapy. Bone marrow aspiration revealed normoblastic hyperplasia with markedly increased amounts of iron. The diagnosis of pyridoxine-responsive anemia was suggested and treatment with pyridoxine, 100 mg daily, was started. The reticulocyte count reached a peak of 12.7% on the fourth day. His hemoglobin concentration rose to 14.1 gm/100 ml. Again, the role of pyridoxine in correction of the anemia was overlooked, and improvement was attributed to iron. He was discharged on INH, PAS, and ferrous sulfate, only to be admitted once more with congestive heart failure and anemia. The hemoglobin level was 7.7 gm/100 ml; hematocrit reading, 27%; RBC, 3,000,000/cu mm. Serum iron was 240 μg%; iron binding capacity, 367 μg%. The bone marrow was hyperplastic with abundant iron. Iron therapy was discontinued and pyridoxine started, 150 mg per day. INH and PAS were continued. The reticulocyte count reached 20% in 6 days. Two weeks later the hemoglobin concentration was 12.3 gm/100 ml. Presently this man is taking INH, PAS, and pyridoxine and continues to be in hematologic remission.

COMMENT

This man was thought to have iron-deficiency anemia for two years. Pyridoxine corrected the anemia on two separate occasions, but the response was erroneously attributed to concomitant iron therapy. Appropriate studies were done to establish the diagnosis of iron-deficiency anemia but at first were misinterpreted. This includes an elevated serum iron, saturated iron-binding protein, and increased deposition of iron in the marrow. The diagnosis of pyridoxine-responsive anemia is best accomplished by observing a reticulocyte and hemoglobin response to a therapeutic trial with pyridoxine.[2]

Cases 4 and 5—Hereditary Sex-linked Sideroachrestie Anemia. Twin boys (Patients 4 and 5, Table 1) were admitted to the hospital at the age of three months because of hydroceles and inguinal hernias. In one patient, at the time of admission, the hemoglobin level was 6.4 gm/100 ml; hematocrit reading, 22%; RBC, 2,850,000/cu mm; MCV, 70 cu μ; MCH, 23 μμg, and MCHC, 30%. The white blood cell count and differential were normal, but hypochromic and microcytic erythrocytes were found on the smear. A similar blood count was described in his twin brother. The serum iron was 310 μg% in one patient. The boys were treated with various oral and parenteral iron preparations for the next three years with no significant change in hemoglobin or hematocrit values. They were referred for further diagnostic studies.

In addition to the previously described hernias and hydroceles, the physical examination disclosed extreme pallor and splenomegaly, 4 cm below the costal margin. Both boys appeared to be somewhat retarded mentally.

Hemoglobin values were similar to those seen at the age of 3 months; if anything, they were even lower. Hemoglobin electrophoresis was normal. In particular, the normal values for A_2 hemoglobin (1.1%) and alkali resistant (fetal) hemoglobin (1.5%) ruled out thalassemia. Osmotic fragility tests disclosed two populations of erythrocytes. One showed beginning hemolysis at 0.44% NaCl and complete hemolysis at 0.36% NaCl. The other population was osmotically resistant as manifested by beginning hemolysis at 0.30% NaCl. Complete hemolysis occurred at 0.20% NaCl. Incubation for 24 hours resulted in initial hemolysis at 0.68% and complete hemolysis at 0.04% NaCl. Autohemolysis was 6.8% (control 1.4%). Glucose corrected this to 1.4% but ATP, adenosine, and ouabain had no significant effect.

A battery of enzyme studies was performed* including those of the Embden–Meyerhof pathway (glyceraldehyde-3-phosphate dehydrogenase, pyruvate kinase, aldolase, phosphoglyceric kinase, phosphofructo-kinase, lactic dehydrogenase) and the hexose monophosphate shunt (glucose-6-phosphate dehydrogenase and phosphogluconic dehydrogenase). Activity of all these enzymes was elevated above normal which indicated the young age of the patient's erythrocytes. Studies on glucose utilization, lactic acid production, and ATP levels were all elevated and indicated that the erythrocytes were in an extremely hypermetabolic functional state, presumably in an effort to compensate for an intrinsic defect.

The answer to the problem was probably found in the bone marrow examination of both patients, which showed extensive deposition of iron. Much of the iron was located in the normoblasts which were identified as "ringed sideroblasts."

Both children were given a trial of pyridoxine without benefit. They continue to be severely anemic and show no changes in their physical or intellectual makeup.

The mother of these boys is not anemic. The father died recently of lymphosarcoma, but had not been anemic prior to the onset of his illness.

* Performed by Dr. Tibor J. Greenwalt and V. E. Ayres, at the Milwaukee Blood Center, Inc.

COMMENT

These twins were considered to have iron-deficiency anemia for three years. The lack of response to iron and the presence of iron in the bone marrow eliminates this diagnosis. The clinical findings and hemoglobin electrophoresis are not compatible with thalassemia. Absence of reticulocytosis and normal levels of red cell glycolytic enzyme appear to rule out any known type of congenital nonspherocytic hemolytic anemia. These studies, and the presence of ringed sideroblasts in the bone marrow, place these children in the category of primary sideroachrestic anemia. Further family studies are necessary to confirm whether this is the hereditary sex-linked variety described by Rundles and Falls.[3]

DISCUSSION

The common denominator of all these patients is erythrocyte hypochromia and lack of response to iron.

Iron deficiency, the most common cause of hypochromic microcytic anemia is manifested by low serum iron, elevated iron binding capacity, total absence of stainable iron from bone marrow and elevated free erythrocyte protoporphyrin values. Patients with iron deficiency must respond to treatment with iron; failure to do so indicates another etiologic factor.

The first patient has thalassemia minor. In this group of diseases, a genetic defect in globin synthesis has been postulated.[4-6] The globin moiety of hemoglobin A consists of four polypeptide chains, two alpha and two beta, each under separate genetic control. Defects in beta chain synthesis are more common in people of Mediterranean origin and it is referred to as beta thalassemia. Since the genes for beta polypeptide chains are closely linked with those for gamma chains (fetal hemoglobin) and for delta chains (A_2 hemoglobin), any defect in beta chain synthesis is apt to be followed by compensatory increase in either of these minor components. For this reason, A_2 or, less frequently, F hemoglobin are increased in beta thalassemia.

The heterozygous state, thalassemia minor, is characterized hematologically by hypochromia, elliptocytosis, target cells and basophilic stippling. Its chief clinical importance is twofold; it may be confused with iron-deficiency anemia and patients may be needlessly treated with iron. Its genetic importance lies in the possibility that two people with thalassemia minor may produce offspring with the serious homozygous thalassemia, Cooley's anemia. This is a severe disease, usually fatal by young adulthood, for which there is no effective treatment but transfusion.

Defective synthesis of hemoglobin may follow inability to make heme. The biosynthesis of heme involves a complex pathway which begins with the condensation of succinylcoenzyme A and glycine to form amino-β-keto adipic acid (AKA). This is converted to delta-aminolevulinic acid (ALA) by the loss of CO_2. Two molecules of ALA condense to form porphobilinogen which then is sequentially converted to uroporphyrin III, coproporphyrin III and protoporphyrin IX. Incorporation of iron into the latter results in heme, which is then combined with 2 alpha and 2 beta polypeptide chains to form hemoglobin.[7]

Pyridoxine is believed to play a role in the initial condensation reaction involving succinyl-co-A and glycine. Deficiency or inactivation of this substance may interfere with heme synthesis at this early stage. Lead interferes with heme synthesis at various stages. It may inhibit formation of AKA then ALA and thus give rise to increased amounts of these intermediates in the urine. It also suppresses formation of porphobilinogen, conversion of coproporphyrin III to protoporphyrin IX and finally with incorporation of iron into protoporphyrin to form heme. The net result of this is to prevent formation of adequate amounts of heme accompanied by the appearance of these heme precursors in the urine.

Interference with transfer of iron to protoporphyrin may result in sideroachrestic anemia. Since the iron is not used, it accumulates not only in the tissues but also as non-hemoglobin iron in the normoblasts. This is usually disposed in a circular fashion around the nucleus, hence the name, "ringed sideroblasts." Bessis and Jensen[8] have shown that the iron of ringed sideroblasts is located and presumably trapped in the mitochondria where it is not available to form heme. In addition, accumulation of iron inhibits earlier stages of heme synthesis.

Sideroachrestic anemia is a sex-linked disorder. It is apt to be seen in the third and

fourth decade and its occurrence in our two young patients is distinctly unusual.

SUMMARY AND CONCLUSIONS

Hypochromic anemia occurs whenever synthesis of hemoglobin does not keep pace with red cell production. Iron-deficiency anemia is the most common cause of hypochromia. This is characterized by low-serum iron values, absence of stainable marrow iron, and therapeutic response to iron. Hypochromic anemia may result from a diminished rate of synthesis of globin polypeptide chains in thalassemia. This is characterized by compensatory increase in the minor hemoglobin components, A_2 or F.

Hypochromic anemia may result from disturbances in heme synthesis. Pyridoxine-responsive anemia and lead intoxication are characterized by interference with the early stages of heme synthesis. Disturbances in the late stages of heme synthesis, may lead to nonutilization of iron by red cell precursors in sideroachrestic anemia.

These forms of hypochromic anemia do not respond to treatment with iron. They are further characterized by high serum iron, saturated iron-binding capacity and the deposition of nonhemoglobin iron in the tissues or around the normoblast nucleus (ringed sideroblasts).

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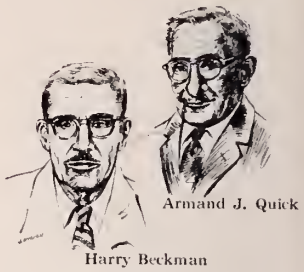

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Intravascular Coagulation, Localized and Diffuse

An Analysis of Its Etiopathogenetic Mechanisms

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■ IT WAS MY PRIVILEGE to be associated with Dr. Armand J. Quick in the early days of my career. I am happy to be asked to write in his honor and I consider it proper that the discussion be in the field to which Doctor Quick has made so many contributions. I would like to present some thoughts on the subject of intravascular coagulation, which is both timely and controversial.

Intravascular coagulation assumes two widely different aspects in human pathology. As a local phenomenon, it leads to the occlusion of an individual vessel, arterial or venous, thus interfering with the circulation of blood in a single segment of the circulation. As a generalized phenomenon, because of diffuse intravascular deposition of fibrin and of marked depletion of coagulation factors, it leads to the paradoxical association of thrombosis and hemorrhage, with resulting many and complex clinical disorders which have been grouped under the general definition of "defibrination syndrome."

A. "Localized formation of thrombi"

Intravascular coagulation in a single district of the circulation leads to the formation of a thrombus which extends along the wall of the vessel and may release emboli. Much is known about venous thrombosis, much less about its counterpart in the arterial side.

(1) *Venous thrombosis* is precipitated by several correlated factors (Fig 1): interruption in the continuity of or damage (traumatic or inflammatory) to the endothelial lining of the vessel; slowing of the blood flow; increased coagulability of the blood contribute synergically. Individual factors vary in importance in different types of localized venous thrombosis. In *thrombophlebitis*, thrombus formation seems related primarily to inflammatory involvement of the vascular wall. In *phlebothrombosis*, it may be related mostly to hypercoagulability of blood, triggered, perhaps, by tissue injury and blood stasis.

Reduction in speed of blood flow in the larger venous vessels is an important pathogenetic mechanism of any type of venous thrombosis. It is produced by a number of

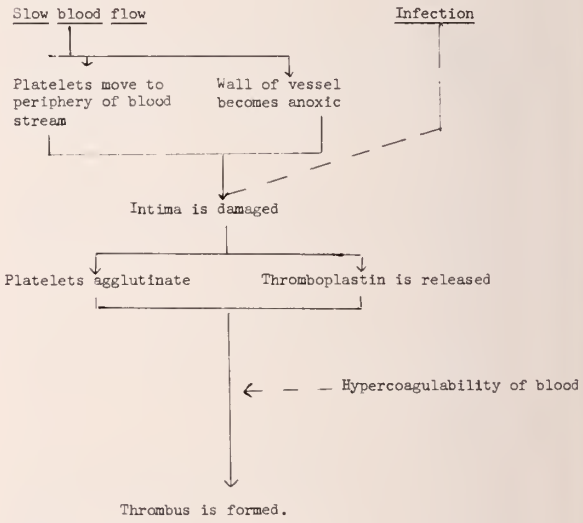

Fig. 1—Etiopathogenesis of venous thrombosis, a hypothesis. This hypothesis does not distinguish between thrombophlebitis and phlebothrombosis. The initial step may be represented by slowing of blood flow which, in turn, brings platelets into contact with the intima. If the intima is damaged by anoxia (stasis), infection or other causes, formation of a thrombus begins. The significance of hypercoagulability in the initiation and propagation of a venous thrombus is discussed in the text.

(Modified from Stefanini, M. and Dameshek, W.: The Hemorrhagic Disorders, 2nd ed., Grune & Stratton, publ., New York, 1962.)

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Fig. 2—Procedure for production of a self-propagating thrombus in a vein of dogs. (a) Application of partially occluding ligatures. (b) Partially isolated segment of vein after removal of rods. (c) Open vessel, three-day-old thrombus. (Marin, H. M. and Stefanini, M.: Surg. Gynec. & Obst. 110:263, 1960.)

factors, among which one can list backward pulsations of veins, weakness of the musculature at points around the walls, angulation and kinking through anatomical position or external pressure. A significant additional cause, under special circumstances, may be increased viscosity of blood (dehydration through excessive sweating, vomiting, or diarrhea; myeloproliferative states; lack of physical exercise; bedfastness, and the like). When the blood current slows up and ebbs begin to form, platelets arrange themselves at the periphery of the blood jet stream. If any injury of the vascular endothelium is present, there platelets agglutinate and undergo viscous metamorphosis. Yet, stasis alone probably does not precipitate formation of a thrombus, as we see it in human pathology. Injection of fresh serum or of thrombin into an isolated segment of intact vein in animals is followed by formation of a ball clot but not of a self-propagating thrombus. Yet, if the intima has been lightly scarified, a thrombus forms quickly and extends to fill entirely the isolated segment of vein.

Intimal injury is of manifest importance in the pathogenesis of venous thrombosis. It may be related to trauma, bacterial infections, allergic and hypersensitivity reactions, and the like. Endothelial lesions are followed by clumping and by viscous metamorphosis of platelets which, in turn, release substances with thromboplastic activity and, possibly, chemicals causing local vasoconstriction (thus, further reducing the speed of blood flow).

Hypercoagulability of blood remains an uncertain entity. It may be a factor in the formation of thrombus or, alternatively, it may only reflect its presence. Perhaps its importance is an individual problem. We have studied a family whose members suffered from repeated episodes of thrombophlebitis. Laboratory-wise, they exhibited greatly accelerated generation of thrombin and of thromboplastin. The latter was corrected by administration of warfarin sodium (Coumadin). As long as medication was given, no thrombotic phenomena occurred; they quickly reappeared, however, upon discontinuation of treatment. In this family, hypercoagulability of blood was demon-

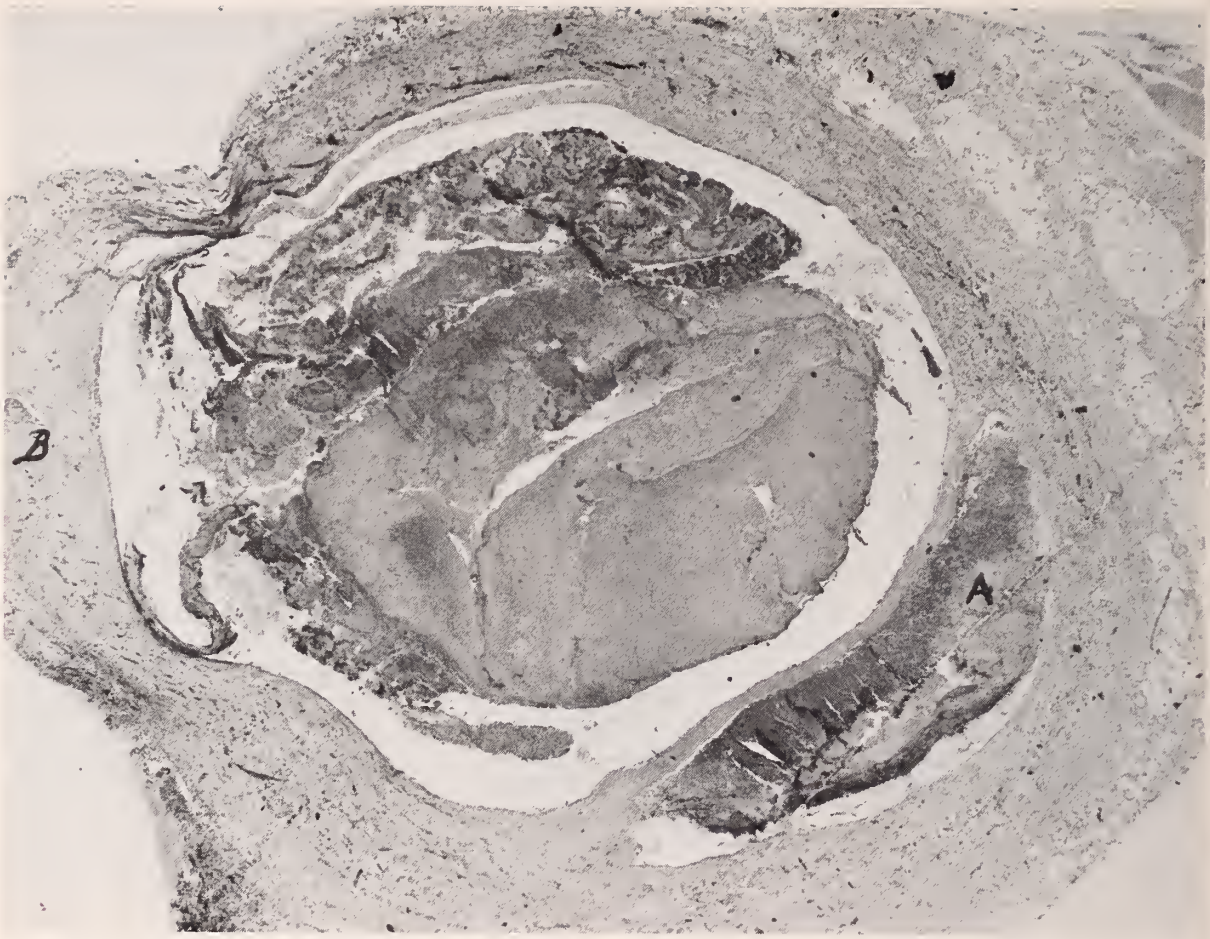

Fig. 3—Ten-day-old specimen. Note lines of Zahn and partial organization of the thrombus which is adherent to wall of the vessel. Note also: (A) thrombus formation within the pocket of a valve and (B) partially organized thrombus in a vessel of the venous wall.

strable and, probably, an important factor in the pathogenesis of recurrent venous thrombosis. We and others have also noted high occurrence of thrombosis in hyperadrenalcorticalism, as result of administration of drugs (digitalis and analogues, antibiotics, and the like), in some disseminated carcinomas. Yet, as a pathologist, I am not impressed by the incidence of thrombotic phenomena in patients with carcinoma of the pancreas, so often emphasized in the older literature. Severe anemia seems more important as a factor predisposing to thrombosis. Hemolytic anemia, in particular, seems to lead to thromboembolic complications, possibly because the lysis of erythrocytes releases products which possess or trigger thromboplastic activity.[1] Treatment of hemolytic anemia with steroids seems to enhance this trend.

In considering venous thrombosis, one should differentiate perhaps between initiation and propagation of a thrombus. A few years ago we carried out experiments on the role of individual factors in the pathogenesis of venous thrombosis.[2-4] A segment of a major vein was occluded partially between two loose ligatures in dogs (Fig 2). Then, homologous serum was injected in the systemic venous circulation. A thrombus formed in the upper corner of the sac which propagated until the portion of vessel was totally occluded (Fig 3). This technique allowed a study of changes in factors and mechanisms related to the coagulation of blood, following the initiation and during the propagation of a venous thrombus. Comparisons could be made in the changes noted in the blood reaching and leaving the partially isolated sac and in the blood from the general venous circulation (Fig 4). Blood emerging from the segment showed reduced number of platelets. The clotting time of platelet-

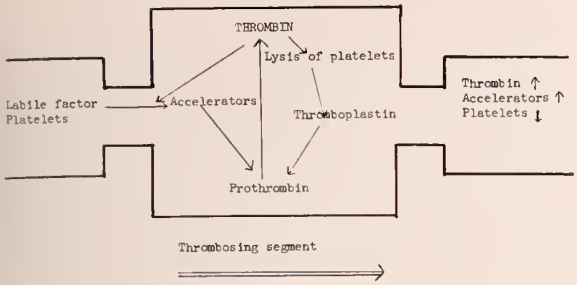

Fig. 4—A hypothesis of the dynamic mechanisms involved in the propagation of the thrombus in a partially isolated segment of vein. Double arrow indicates the direction of blood flow. Formation of a thrombus causes conversion of the labile factor and, possibly, of other factors, to accelerators of the conversion of prothrombin to thrombin. It also induces lysis of platelets in the presence of plasma factors. Results are: (a) faster formation of thromboplastin and of thrombin, (b) continued deposition of platelets and of fibrin within the partially isolated segment, and (c) differences between inflowing and outflowing blood, reflecting these changes.

poor plasma upon recalcification was accelerated, suggesting the release of clot accelerators, probably from platelets. Labile factor (Factor V) showed enhanced activity, presumably because of its conversion to a powerful accelerator. Generation of thromboplastin and of thrombin also continued in accelerated, logarithmic, explosive fashion. Within 30 minutes after the thrombus had begun to form, an antithromboplastin appeared, which persisted for two hours or so. Blood reaching the segment undergoing thrombosis and blood from the systemic circulation showed no significant changes. Thus, in the propagation of a thrombus, "local" hypercoagulability of blood plays an obviously important role. It is of interest also that the components of the fibrinolytic system showed no significant changes during the active propagation of the venous thrombus. Plasmin (fibrinolytic) activity was increased slightly in the early phases, but it returned to normal within 30 minutes in a sample of plasma from the general circulation and within 60 to 120 minutes in samples of blood leaving the area of thrombosis. Changes in antiplasmin were reciprocal to those in plasmin activity.

These results clarify, to some extent, the sequence of events during the propagation of a venous thrombus. However, they do not supply light on the mechanisms of initiation of the thrombus which, perhaps, results from the combined effects of the entrance in the blood stream of clot-promoting substances in the presence of a minimal injury to the vessel. The validity of these observations as they may apply to human pathology is supported by the fact that the morphologic evolution of the experimentally produced thrombus is similar to that observed in human phlebothrombosis. Of interest in these days of thrombolytic therapy, is the finding that the fibrinolytic mechanisms, at least in the dog, are inadequate to prevent extension of a thrombus. This observation may point to the potential therapeutic value of thrombolytic (fibrinolytic) agents.

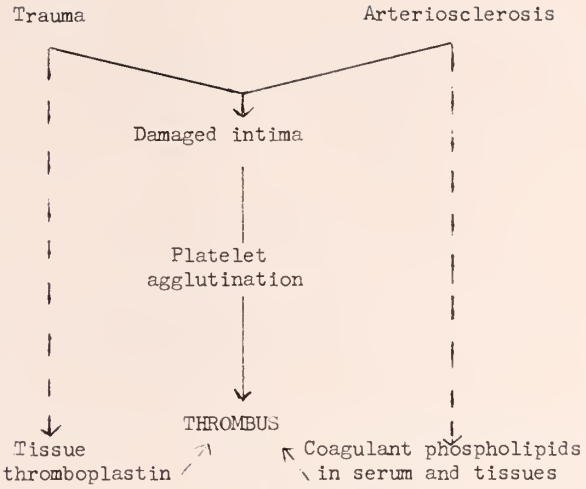

Fig. 5—Etiopathogenic mechanisms of arterial thrombosis. Changes of the intimal wall related to atherosclerosis or, more rarely, to other disease processes, are most important. Local hypercoagulability may be significant also and may be produced by tissue destruction and by changes in the chemical structure of the vessel wall (see text).

(Stefanini, M. and Dameshek, W.: The Hemorrhagic Disorders, 2nd ed., Grune & Stratton, New York, 1962.)

(2) *Arterial thrombosis* represents a widely different problem (Fig. 5). Most of the available information results from analytical studies of coronary and cerebral thrombosis, but it probably finds equal application to the problems of the occlusion of any other arterial district. Trauma (and consequent damage to the intima) is probably of significance in thrombosis of arteries of the extremities. Elsewhere, atherosclerosis and arteritis probably play a major role. The very distribution of agents favoring and opposing coagulation of blood within the arterial wall may bear a definite relationship to the occurrence of thrombosis. Thromboplastic activity seems located at the level of the intima, agents promoting lysis of the clot are located in the adventitia. Injury to the wall, affecting the

A PATHOGENETIC CLASSIFICATION OF INTRAVASCULAR CLOTTING

A. Massive entrance of thromboplastic material into the blood stream

(1) Burns

(2) Transfusion reactions
Hemolytic reaction
Buffy coat, plasma reactions

(3) Surgical trauma
Operations involving lung, prostate, pancreas,* uterus, and the like

(4) Accidents during delivery and pregnancy
Eclampsia
Intrauterine fetal death
Separation of placenta
Amniotic embolism
Meconium embolism

(5) Embolization by tumor "plugs"

(6) Hemorrhagic, other types of shock

B. Acute vasculitis

(1) Experimental (Sanarelli–Shwartzman's phenomenon, Masugi's nephritis, and the like)

(2) Clinical
Polyarteritis nodosa and necrotizing angiitis
Lupus erythematosus disseminatus, other "autoimmune disorders" (so-called)
Thrombohemolytic thrombocytopenic purpura

C. Miscellaneous, ill-defined mechanisms

(1) Multiple replacement transfusion syndrome

(2) Polycythemia vera
Anoxic (secondary) polycythemia
Myeloproliferative disorders with thrombocytosis, and the like

* Trypsin may be the responsible agent in this case. At small concentrations, it activates clotting; at higher concentrations, it activates the fibrinolytic mechanism and shows rather indiscriminate lytic activity on several clotting factors.

Figure 6

intima first, would cause primarily release of clot promoting factors. Along a different avenue, thrombosis within arterial vessels is seldom seen in the absence of atherosclerosis. Chemical analysis of atherosclerotic plaques shows high content in phospholipids and, among them, of phosphatidylserine, phosphatidylethanolamine and lecithin. These agents, in various combinations, are able to replace platelets in the thromboplastin generation test and, thus, possess strong coagulant activity. Their presence at the site of intimal damage is likely to facilitate occurrence of a thrombus. To complicate the picture further, however, it should be remembered that infarction of myocardium, brain and other organs may be due to causes unrelated to the formation of a thrombus at the level of an atherosclerotic plaque. Occlusion to the circulation may follow bleeding within an atherosclerotic plaque. Finally, disproportion between lumen of coronary arteries, for example, and the need for blood supply of a particular area of myocardium may also cause infarction severe enough to be cause of death. Thus, the pathologist called to determine the cause of sudden death in a young or middle-aged man with little evidence of atherosclerosis may find a coronary tree which is essentially healthy but for too small arteries to meet the expected blood requirements in the various areas of the myocardium. Obesity, congenital anomalies of coronary arteries, and stress may be involved also.

The relationship of arterial thrombosis to emotion, tension, overwork ("stress") remains hazy, primarily because the very concept of stress remains nebulous, if not mystic. The role of smoking is probably significant in coronary and peripheral thrombosis, although its mechanism remains highly theoretical.

B. Diffuse intravascular coagulation

It is likely that there goes on in the human blood stream a continuous process of intravascular coagulation, resulting in deposition of fibrin along the vessel wall, even under normal conditions. This concept, originally advanced by Rokitansky and by Aschoff, has been more recently reemphasized by Duguid, Astrup[5] and ourselves,[6] and is confirmed by studies with fluorescein-tagged or I^{131}-tagged fibrinogen. The syndrome of "diffuse intravascular coagulation" is probably an exaggeration of such phenomena. It represents a common denominator for many clinical pictures and is probably a pathogenetic mechanism of disease as basic as infection and immunity.

The syndrome presents itself in a heterogenous group of clinical disorders which, on the basis of their pathogenesis, may be classified in three major variants (Fig 6). In a *first group*, clot-promoting materials (placental tissue; amniotic fluid; constituents of erythrocytes, leukocytes and platelets; lipids

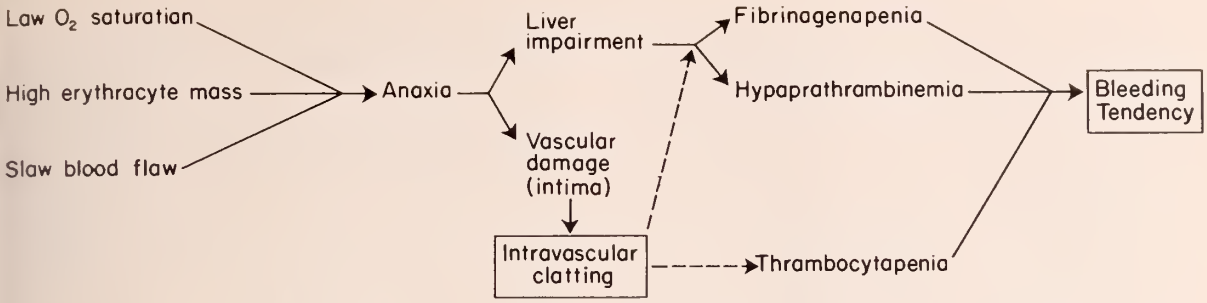

Fig. 7—The combined bleeding and thrombotic tendency in polycythemic states. Low saturation of oxygen, high viscosity of blood, and slow blood flow related to high red cell mass cause anoxia; this, in turn, induces some impairment of liver function (hence, reduced synthesis of fibrinogen, prothrombin, and other clotting factors) and damage to vascular intima (which seems to initiate intravascular clotting). Intravascular coagulation, in turn, aggravates the deficiency of clotting factors and induces thrombocytopenia and fibrinogenopenia of high severity.

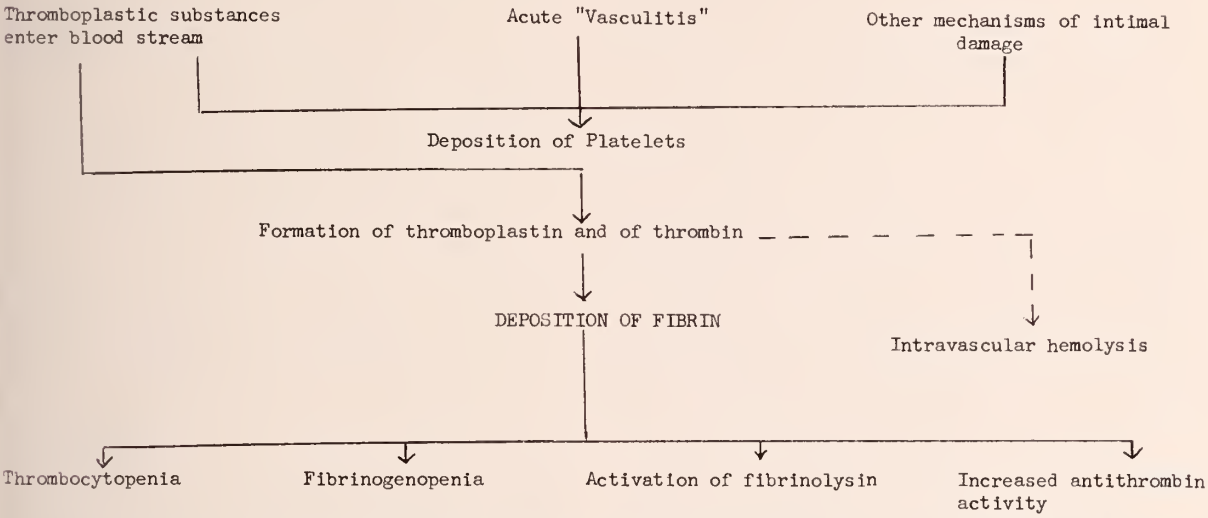

Fig. 8—A hypothesis of the mechanisms and effects of generalized intravascular coagulation (see text). Entrance of thromboplastin-like substances into the blood stream or intimal damage (however produced) initiates intravascular formation of thromboplastin and of thrombin, as well as precipitation of platelets. Thrombin, which also possesses a direct hemolytic activity, gels fibrinogen into fibrin which is deposited along the vessels. Final results of intravascular coagulation are thrombocytopenia and fibrinogenopenia (as well as depletion of practically all factors taking part in the coagulation of blood). The activation of fibrinolysis and the increased antithrombin activity probably represent compensatory and defensive mechanisms mobilized by the occurrence of intravascular coagulation.

from many tissues, and the like) gain entrance into the circulation and trigger formation of fibrin. The best known syndromes in this group include fibrinogenopenic accidents of pregnancy and delivery; generalized bleeding following trauma, burns, transfusion reactions and some surgical procedures. The syndrome of thrombohemolytic (thrombotic) thrombocytopenic purpura typifies a *second group* (acute vasculidites). Widespread injury to the intima induces generalized "precipitation" of platelets, fibrin, and other clotting factors. Studies with fluorescein-tagged anti-human fibrin antibodies document the massive intravascular deposition of fibrin and show histologic features similar to those encountered in the Sanarelli–Shwartzman's phenomenon. A similar sequence of events probably occurs in the so-called "collagen" or "autoimmune" disorders. A *third group* is typified by some myeloproliferative disorders. High red cells mass, elevated viscosity of blood, and consequent anoxia of the vascular wall with damage of the intima are followed by diffuse intravascular clotting (Fig. 7).

Since intravascular clotting means utilization (and, thus, depletion) of coagulation factors within the blood stream, severe bleeding tendency is encountered. The paradoxical situation develops then of a patient who bleeds because of lack of coagulation

factors, while his vessels are lined by fibrin useless to him and formed through thoughtless utilization of the very agents he is lacking. The clinical picture includes petechiae, ecchymoses, and internal hemorrhages. Typical laboratory findings include striking thrombocytopenia and fibrinogenopenia; also, development of clotting accelerators and activation of the fibrinolytic system (Fig. 8). The activated fibrinolysin, digesting fibrinogen, releases a potent heparin-like anticoagulant, further contributing to the bleeding tendency. Thrombin being formed within the blood stream, attacks red cells and causes intravascular hemolysis. These findings are essentially similar to those seen following intravenous administration of thromboplastin to experimental animals.[7]

Because of the pathogenesis of the bleeding tendency in the syndrome of diffuse intravascular coagulation, the use of heparin for its control has been recommended. We first advised this approach in 1953 for the management of thrombohemolytic thrombocytopenic purpura.[8] Our results in other cases and those of others in a variety of clinical syndromes have been sometimes successful, sometimes disastrous, as the use of heparin in these patients carries with it the danger of marked aggravation of the hemorrhagic manifestations.

The preceding discussion is hypothetical and almost certainly guilty of oversimplification. It is an attempt to bring together many experimental data and ideas which, at the present time, are in a state of uncertainty and flux.

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ACUTE SUPPURATIVE CHOLANGITIS

A. Peter Haupert, M.D., Larry C. Carey, M.D., William E. Evans, M.D. and Edwin H. Ellison, M.D., Division of Surgery, Marquette University School of Medicine, Milwaukee, *Arch. Surg.* 94:460–467 (Apr) 1967.

Fifteen cases of acute suppurative cholangitis are presented. Each had frank pus in the common duct. Twelve were explored as an emergency procedure with four deaths. One died before surgery could be performed. Two developed the condition following elective common duct exploration. Surprisingly only two patients manifested Charcot's triad.

Death was related to failure to make the diagnosis preoperatively, delay in biliary decompression, failure to use a combination of appropriate antibiotics, and acute renal failure.

THROMBOEMBOLISM SYMPOSIUM PAPERS PUBLISHED BY WHA

The Wisconsin Heart Association has recently published the papers given at a symposium for physicians on "Thromboembolism", Sept. 14, 1966, sponsored by the Adolf Gundersen Medical Foundation and the Wisconsin Heart Association's La Crosse County Heart Unit.

Principal speakers and their topics are: Donald Tow, M.D., assistant professor of medicine and radiology at Johns Hopkins University School of Medicine at Baltimore, Maryland, "Diagnostic Procedures in Pulmonary Embolism;" Louis R. M. Del Guercio, M.D., associate professor of surgery, Albert Einstein College of Medicine, New York City, "Clinical Physiology in the Management of Pulmonary Embolism;" Simon Sevitt, M.D., consultant pathologist, Birmingham Accident Hospital and Burns Unit—Birmingham, England, "Prevention of Thromboembolism by Oral Anticoagulants;" Robert R. Linton, M.D., consultant surgeon to the Massachusetts General Hospital, Boston, and assistant clinical professor of surgery emeritus at Harvard Medical School, "The Prophylaxis and Treatment of Thromboembolic Disease—A Surgeon's Viewpoint;" and Ben Lawton, M.D., senior thoracic surgeon at the Marshfield Clinic, Marshfield, "Pulmonary Embolectomy."

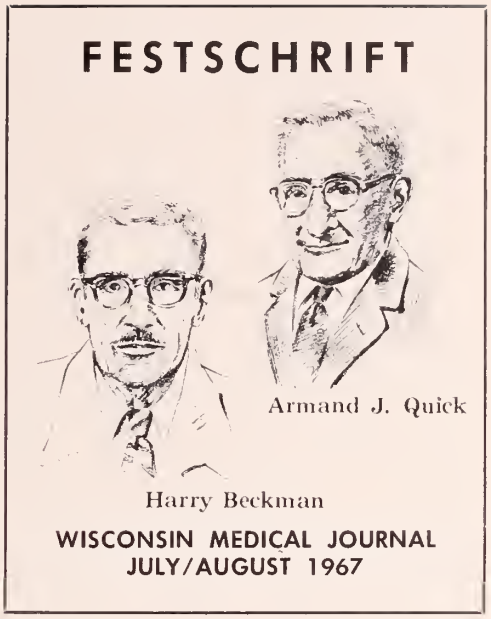
The publication is available in limited quantities from the Wisconsin Heart Association at $1.00 per copy. Write the Wisconsin Heart Association, 205 W. Highland Ave., Milwaukee, Wisconsin 53203.

THE AMERICAN CANCER SOCIETY publishes booklets and brochures on prevention, detection, diagnosis and treatment of cancer. These educational materials are available free to members of the medical profession from the local ACS offices.

Tooth Extraction in Hemophilia

Brief Review of the Literature with Some New Suggestions for Management

By W. F. STAPP, M.D., Jackson, Mississippi



■ THE PROBLEMS of tooth extraction in hemophilia may still be present in spite of the widespread use of transfusions of blood plasma and plasma fractions (Fibrinogen—containing antihemophilic globulin or AHG). The maintenance of a theoretical hemostatic level of Factor VIII (AHG)—of 5.5% of normal, has been proposed by various authors as an effective range for the management of bleeding in hemophilia. However, it has been shown that the maintenance of 5% or better Factor VIII level does not always answer all of the problems of bleeding with these patients.[1,2]

In attempting to maintain high levels of Factor VIII, some authors have recommended the use of purified plasma fractions from animal sources.[3] However, this approach results in an increase in the cost of surgical management of tooth extractions by requiring periodic transfusions of plasma or plasma products from human or animal sources over an extended period of time. The use of animal products (bovine, in this instance) is by nature, foreign, and results in immunization of the patient to bovine proteins.

There is increasing evidence that other factors, i.e., platelets, platelet factors, vascular factors, intravascular factors in addition to blood clotting factors, neurogenic factors, and extravascular factors play very important roles in maintaining hemostasis or controlling bleeding in hemophilia. The roles that these other factors play may be as important as, if not more so, than the plasma levels of Factor VIII (AHG).

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In view of the recent preliminary report by Stapp and associates,[1] the author would strongly recommend the minimal use of fresh human plasma in conjunction with other more local measures. This approach allows for the maintenance of a satisfactory state of hemostasis in the patient, reserving the use of plasma fractions from animal sources for the greater emergency surgical problems. The use of animal materials is not without its immunologic problems and risks.

DISCUSSION

For purposes of discussion, the management of tooth extraction in hemophilia can arbitrarily be subdivided into (a) definitive measures and (b) symptomatic treatment, with the latter being further subdivided into: (1) systemic or (2) local treatment.

Definitive measures, by definition, are those that eliminate the cause of anticipated bleeding based on diagnosis prior to surgery. In the case of classical hemophilia (AHG deficiency, Factor VIII deficiency), the consensus would be that this would be best accomplished by transfusion just prior to dental surgery, with either fresh whole blood (preferably less than 6 hours old); fresh plasma processed from fresh whole blood; recently thawed fresh frozen plasma;[4] lyophilized fresh plasma (AHG Plasma) which is prepared from freshly drawn and processed blood; specific plasma fractions

from fresh human plasma—such as Cohn's Fraction I[5] or Fibrinogen Fraction which is also rich in AHG Factor,[6,7] Blomback's Fraction I-0,[8,9] Pavlovsky's tannic acid AHG rich plasma fraction;[10] Keckwick et al's ether precipitated AHG rich plasma fraction;[11] Dormont et al's AHG rich plasma fraction;[12] Wagner et al's amino acid precipitated AHG rich plasma fraction;[13] or specific AHG fractions from animal sources (bovine and porcine plasma).[3]

In regard to definitive measures, although some authors recommend that the hemophiliac should be transfused with plasma or plasma fractions until his AHG level is 30% to 50% of normal,[3,14] Quick[15] among others,[16,17] has found that effective hemostasis could be accomplished with less plasma —with resulting concentrations of AHG probably not more than 15% of normal. Stapp and associates also found this to be true in their Case 1 reported elsewhere.[1] Waaler[18] has recommended maintaining the AHG levels above 15%, Langdell[19] has recommended maintaining the AHG levels between 5% and 10%, van Creveld and Mochtar[16] have recommended a minimum level of 4% to 6% AHG, and Deutsch[17] recommends the use of 3 ml of reconstituted dry plasma per kilogram of body weight of the patient just before extraction of teeth. According to Langdell,[10] one must give approximately 1 ml of fresh normal plasma per kilogram of body weight to increase the AHG activity 1%. Brinkhous et al[20] have recommended an initial large priming transfusion, approximately 1% of the body weight followed by smaller maintenance transfusions (about 0.5 body weight) at frequent intervals. According to a recent study by Newcomb and Watson,[2] the hemostatic level of AHG was difficult to define, since many of their patients had bleeding episodes with AHG levels ranging from 20% to 44% of normal. The latter authors concluded that any Factor VIII (AHG) given in excess of the amount necessary for hemostasis is wasted and that such waste increases as the need for Factor VIII is increasingly exceeded. Marlette and Gerhard[7] recommended the intravenous administration of human fibrinogen approximating 0.3 gm/Kg of body weight in 5% glucose and water. In Stapp et al's recent report,[1] although the AHG level in their Case 2 was probably within normal limits following transfusion therapy (or at least within normal hemostatic levels), the patient continued to ooze blood from the extraction site. This suggests that the AHG level was not the patient's only difficulty that contributed to his bleeding.

Fresh blood, fresh plasma, or fresh plasma fractions are also given postoperatively shortly following the extraction(s) and usually no later than four hours following surgery. Periodic transfusions may then be given at scheduled intervals, varying with the hematologists under whose care the hemophiliac is placed. Customarily this is given at intervals of 6 hours for the first 24 to 48 hours, then at greater intervals of perhaps one transfusion every 12 hours to one every 24 hours. Some recommend the use of one pint of blood every 24 hours. Other authors recommend continuation of plasma transfusions at intervals to prevent bleeding and still others may give additional plasma only when oozing from the tooth socket recurs.

In the above mentioned report[1] of Stapp and associates with their Case 1, a severe hemophiliac, the use of prolonged periodic transfusions was not necessary and periodic oozing was controlled by other local measures. In addition, in their case of mild hemophilia (Case 2), transfusions of lyophilized fresh plasma alone did not prevent the secondary or "after-bleeding" following tooth extraction; whereas, other local and systemic measures did control the secondary bleeding.[1]

Generally speaking, the author feels that it is most important that fresh blood, fresh plasma, or plasma fractions be given immediately preoperatively; and postoperatively, probably not later than 4 to 6 hours following surgery. As to whether other measures can replace the use of periodic plasma or blood transfusions, as was demonstrated in the preliminary study of Stapp et al,[1] remains to be demonstrated more conclusively by further investigations.

For the purpose of estimating the theoretical increase in Factor VIII levels following transfusions, the author found the formula proposed by Newcomb and Watson[2] to be quite satisfactory. According to Newcomb and Watson, the plasma volume for patients under age 10 was calculated at 45 ml/Kg,

and that for adults was calculated as 41 ml/Kg. The predicted Factor VIII level was calculated as follows:

$$\text{Factor VIII}_1 = \text{Factor VIII}_0 + \frac{100\%\ P}{V}$$

With Factor VIII_1 = post-transfusion plasma Factor VIII in per cent

Factor VIII_0 = pre-transfusion plasma Factor VIII in per cent

P = plasma equivalent administered (in ml)

V = plasma volume (in ml)

The above differs slightly from the formula of McMillan and associates,[21] and ignores the contribution to plasma volume of the infused or transfused material, but only produces a mathematical error of less than 0.1%.

In regard to symptomatic treatment, Quick[22] has pointed out the three cardinal points for local treatment of bleeding in hemophilia are: (1) rest, (2) application of cold, and (3) application of pressure. Mental rest, made possible by the judicious use of sedation and tranquilizing drugs, will allay anxiety and fear. Bed rest with the head elevated should be considered mandatory. Quiet and orderly surroundings, avoidance of needless movement, immobilization of the bleeding site, and minimized talking by the patient are definitely desirable. To the above, we should add that adequate narcotics to relieve pain are strongly recommended for the first 24 to 48 hours. The use of a chilled fortified liquid diet is also advisable to help maintain continued immobilization of the bleeding site.

The application of cold has been used almost routinely following tooth extraction to reduce both swelling and bleeding and many authors recommend it; however, Roskam[23] has experimental evidence to indicate that it should *not* be used *as an aid* for hemostasis because after the initial vasoconstriction, there is a vasodilatation following application of cold. Application of cold was not used in the management of Stapp and associates' Case 1, and other measures proved to be adequate.

There is an overlapping in certain aspects of definitive and symptomatic management of tooth extraction in hemophilia. This occurs in both subdivisions of the symptomatic category; i.e., (a) systemic measures and (b) local measures—if we consider that bleeding in hemophilia may be due to a vascular abnormality (which may be temporary) in addition to the known plasma coagulation factor defect. Therefore, any measure that could improve hemostasis may be definitive (in that it may help to correct a known bleeding tendency) and symptomatic —systemic or local.

A partial list of systemic measures may include the following:

1. Transfusion of fresh whole blood, fresh plasma (frozen or lyophilized) or plasma fractions, etc.—which correct a known plasma coagulation defect and exert a systemic effect.
2. Injections of antihistamines—along with the blood, plasma, or plasma products—to combat any sensitivity reactions resulting from the transfusions (diphenhydramine hydrochloride [Benadryl]—10 to 50 mg—depending upon the individual's tendency to reaction is usually sufficient for this purpose). Antihistamines are also believed to aid in healing.[24]
3. Use of supportative therapy such as liquid food concentrates (Lipomul, Sustagen, etc.), multiple vitamins, iron compounds, Vitamin C, and rutin —during the postoperative healing phase when eating movements should be minimal.
4. Use of a local dicarboxylic acid preparation which is supposed to aid in hemostasis and act systemically through absorption into the blood stream (Koagamin—Dental Sublingual Hemostat).[1,25]
5. Use of sedatives, tranquilizers, and minimal narcotics—postoperatively and judiciously thereafter as required.
6. Intravenous and intramuscular injections of dicarboxylic acid preparations which are supposed to aid in hemostasis (Koagamin–Injectable—containing oxalic and malonic acids).

A partial list of local measures may include the following:

1. Attempt to make the extraction(s) as atraumatic as possible and to handle soft tissues gently.
2. Application of *pressure* with "Bipp's" gauze placed into the tooth socket, first by digital pressure then by use of a gauze "bite" on top of the socket packing. The "Bipp's" gauze placed in the

tooth socket is *not* removed, but is trimmed on successive intervals as granulation tissue forces it occlusally.

3. Suturing of gingival flaps after removal of spicules and subsequent removal of sutures in approximately 48 hours postoperatively.
4. Use of local dicarboxylic acid preparation, Koagamin–Dental Sublingual Hemostat (K–DSH) before injection of local anesthetic—to get combined hemostatic effect of anesthetic and the dicarboxylic acid preparation and to prolong the anesthesia. Use of K–DSH before suture removal is also recommended.[1]
5. Use of local anesthetic both for its anesthetic property and for its hemostatic property.
6. Use of moistened surgical cotton as a "protective" pack over the surgical site to protect it from tongue movements and to replace the gauze "bite" which is used up until about four hours postoperatively.[1]
7. Some authors recommend the use of acrylic splints, compound splints, Barton and spica head bandages, etc., to protect the surgical site and for purposes of immobilization.
8. The use of Gelfoam, oxidized cellulose, or fibrin foam—soaked in a dilute solution of topical thrombin, and placed into the tooth socket has been recommended by many authors.
9. The topical application of the following agents to the bleeding site has been recommended by various authors: thrombin powder, thromboplastin, fibrinogen (which incidentally usually has varying concentrations of Factor VIII as a "contaminant"), snake venom—Stypven, epinephrine, Monsel's solution, tannic acid, Gelfoam, oxidized cellulose with phenylmercuric nitrate, turpentine, phenosulfonic acid, and carbolized resin. The topical application of the dental sublingual hemostat (K–DSH) to the bleeding site (in addition to its application over the sublingual veins) may also be of benefit. Birch and Snider[26] have an excellent account of the various local agents used before 1939.
10. Electrocautery has been used and is useful when applied directly to the tip of the bleeding vessel. It should be used with caution because of the tendency of the treated area to "slough" out.
11. In extreme cases and very rare instances, ligation of the external carotid artery may be used as a last resort. In addition to the above some oral surgeons prefer to use general inhalation anesthesia, in place of local infiltration anesthesia or nerve block, in order to eliminate the bleeding that may occur from needle trauma.

In the cases presented in Stapp and associates' preliminary report,[1] the authors used the first five measures from the list shown above of systemic measures and the first six from the list of local measures.

In his recent study of hemophilia in Finland, Ikkala[27] has stated that "Lacerations of the oral mucosa constitute a far greater problem than cutaneous wounds for the hemophiliac since it is impossible to apply easily to the latter the main principles of wound therapy, viz., compression and immobilization, which often suffice even in hemophiliacs to staunch minor hemorrhages. The application of this treatment in the oral region is generally impossible."

In his monograph, Roskam[23] states: "The facts disclosed by the analytical study of spontaneous hemostasis have undoubtedly proved that:

1. The arrest of bleeding through minute vessels (small arteries and venules) depends upon the agglutination of blood platelets at the mouth of the vascular wound which leads to the formation of a white thrombus acting as a hemostatic plug;
2. The arrest of capillary bleeding (if such bleeding is not prevented by adherence of endothelial cells) depends upon a blood coagulation·
3. The firmness of the hemostatic plug which prevents a renewed bleeding, depends upon normal blood coagulability;
4. The injury of a minute vessel (arteriole or venule) results in a localized vasoconstriction, whose participation in spontaneous hemostasis is probable."

In 1949, Quick[28] described the blood platelets as having three distinct functions in hemostasis: (1) participation in the forma-

tion of thrombin, (2) formation of white thrombi to serve as plugs for staunching, and (3) vasoconstriction.

In a recent report, Brinkhous[29] has stated: "Formation of thrombin at the bleeding site seems to be important, not only for the formation of fibrin, but also for the formation of the platelet agglutinates, or the white or hemostatic thrombus. The pathophysiologic problems pertaining to the formation of the hemostatic platelet clot are possibly more complicated than blood coagulation; however, the solution of these problems may furnish a way of bypassing the clotting defect in hemophilia, now correctable for only a limited time by great effort."

There is practically universal agreement with regard to the importance of the use of pressure in controlling bleeding. Stapp et al,[1] as well as Finkelman,[30] differ from those who advocate the removal of the socket packing in the hemophiliac 24 to 48 hours following surgery. The author and associates[1] recommend that one should allow the internal packing to remain in the socket, and to trim it as it becomes dislodged by granulation tissue forcing it occlusally.

There is some difference in opinion as to the suturing of gingival flaps postoperatively in the hemophiliac. Some authors mention it, while others strongly advise against it for fear of pressure necrosis and of causing additional hemorrhage on removal of the sutures. Stapp and coworkers[1] had no difficulty in the latter respects and found that use of local measures (use of K-DSH, pressure, and protecting the surgical area) eliminated the oozing of blood that usually follows removal of gum sutures in the hemophiliac who has not been transfused just prior to suture removal.

In a recent preliminary report, Stapp and associates[1] described their experiences in the use of sublingual hemostatic agent, Koagamin-Dental Sublingual Hemostat (K-DSH), to help control the secondary bleeding that follows tooth extraction in hemophilia. In addition the authors postulated that the beneficial effects of the K-DSH was due to its action upon blood platelets which initiated a chain of events that promoted ultimate *local* hemostasis.

There is general agreement that the newly formed clot and tooth socket area should be protected. Many authors recommend the use of acrylic splints for this purpose. The author has found that the use of moistened surgical cotton, fashioned to fit over the surgical site comfortably, is adequate for this purpose.

In essence, the main measures (both systemic and local) that Stapp et al[1] have used and that the author feels should be recommended for management of tooth extraction in the hemophiliac can be summarized in the following outline:

Use of:

1. Transfusions of fresh whole blood, fresh plasma (frozen or lyophilized) or plasma fractions, both preoperatively and postoperatively. Fresh whole blood is not indicated unless the hemoglobin and hematocrit reading are lowered significantly. Factor VIII levels of 5% should be adequate, provided that the other measures that are recommended are taken.
2. Antihistamines along with plasma or blood.
3. A local dental hemostatic preparation (K-DSH) before local infiltration anesthesia, before removal of gingival flap sutures, and for postoperative control of "secondary" bleeding.
4. Local infiltration anesthesia.
5. An atraumatic as possible extraction procedure and to handle soft tissue gently.
6. "Bipps" gauze for intra-socket packing which is allowed to remain in place until it is pushed out by regenerating tissue.
7. Sutures for gum flaps.
8. Pressure gauze "bite" for first 4 hours following oral surgery, to be replaced by a cotton pack or "bite," which is in turn covered by a "protective" cotton covering which is shaped to fit comfortably and snugly over the cotton pack and surgical site to protect the latter from tongue movements.
9. Continued use of "protective" cotton covering during healing phase.
10. Sedatives, tranquilizers, and minimal narcotics postoperatively and judiciously thereafter as required.
11. Supportative therapy such as liquid food concentrates during early healing phase to be followed by soft diet and regular diet when applicable.
12. Bed rest with head elevation.

13. Ice bag to side of face for anesthetic effect and to minimize swelling. It may or may not reduce bleeding.

In addition to the dental preparation (K-DSH) being useful in tooth extraction in hemophiliacs, the author has found it is also of benefit in the prophylactic periodontal care of these patients and thereby should cut down on the ultimate cost of care to the hemophiliac. Zegarelli and associates[31] have recently suggested more extensive periodontal care for the purpose of cutting down on the cost of dental care (tooth extraction) for hemophiliacs. The author has used the K-DSH in one case of severe hemophilia on several occasions before having the patient's teeth cleaned, and bleeding at the gum margins, following the cleaning, was considerably less than usually experienced. In view of this experience, the K-DSH may also be of some value in the treatment of bleeding from the oral mucosa of the hemophiliac child or adult, who has accidentally bitten the inner aspect of his buccal mucosa.

SUMMARY

An attempt has been made to review the most relevant literature pertaining to the management of tooth extraction in hemophilia. For purposes of discussion, management was arbitrarily subdivided into (a) definitive measures and (b) symptomatic treatment, with the latter being further subdivided into (1) systemic or (2) local treatment.

The measures recommended for management of tooth extraction in hemophilia were outlined. In addition, measures applicable to other dental care of the hemophiliac were suggested.

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A Reevaluation of the Continuum of States of Central Nervous System Depression and Excitation

By WALLACE D. WINTERS, M.D., PH.D., CHARLES E. SPOONER, PH.D. and KENJIRO MORI, M.D., Los Angeles, California

■ THE CHIEF RESPONSIBILITIES of anesthetic agents are to protect the patient from the distressing and dangerous effects of the required surgical procedure and to produce relaxation or paralysis when needed.[1] This protection has four basic requirements: (1) sensory block—analgesia; (2) mental quiet—unconsciousness; (3) motor block—motor relaxation; and (4) the prevention of adverse effects. Those agents which are utilized to perform this task form a diffuse group of pharmacologic agents which are generally classified as central nervous system (CNS) depressants.

The pharmacology of anesthetic agents is often presented by a schema indicating that anesthesia is a progression of decreasing states of CNS irritability leading to marked depression and finally death.[2] In contrast, increasing states of irritability represent a continuum in the opposite direction leading to hyperexcitability, convulsions, and death. Unfortunately, this scheme is a two dimensional representation which does not explain all dimensions of consciousness. For example, if depression is a continuum of decreasing irritability, then where do slow wave sleep and dream sleep belong?

The underlying theme of this presentation is to ask the question: are all agents used in anesthesiology truly anesthetic agents? If not, then what is the anesthetic state? Further, we ask whether there is any evidence for a continuum of excitatory states comparable to the stages of anesthesia described by Guedel.[3]

To answer these questions studies were undertaken in a manner that permitted a correlation of spontaneous gross behavior with the ongoing electrical activity of cortical and subcortical brain structures. Based on these parameters various stages of wakefulness, sleep, and drug-induced states were obtained. This presentation represents a review of previously reported studies[4-11] utilizing these and more sophisticated neurophysiologic techniques.

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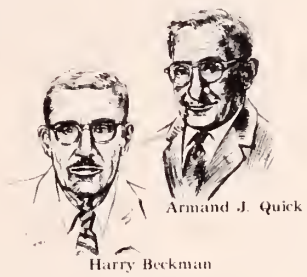

METHODS

Cats weighing between 2.5 and 4.6 Kg were utilized for these studies. The animals had chronically implanted monopolar cortical and bipolar subcortical leads. The cats were placed in a sound-attenuating, screened box and observed through a one-way window during each experiment.

RESULTS

Sleep Studies

Preliminary studies in our laboratory confirmed three basic states of wakefulness and sleep; *i.e.*, awake, slow wave sleep, and dream sleep, also called paradoxical sleep or rhombencephalic sleep (RPS). In addition we demonstrated that electrically the highly alert or alert distracted cat was most similar to RPS.[4] This point is of more than academic interest since many investigators claim that RPS is a deep state of sleep. If deepest sleep

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and the highly alert state are electrically identical, then it is not likely that behavior and brain activity are related, thus attempts to correlate behavior and electrical brain activity would be futile. However, in examining the rationale for the conclusion that RPS is deep sleep, it was apparent that the major criterion was based on the finding that the animals are less responsive to stimuli during RPS as compared to slow wave sleep. It has been assumed that the deeper the state of sleep, the less responsive the subject will be. However, there are many situations in which this premise does not apply. For example, catatonia, orienting, alert distracted, hallucinatory and epileptic states are all examples of reduced responsiveness during excited rather than depressed states. On the basis of our studies, their relationship to other investigations and a reevaluation of apparently contradictory findings, it appears that RPS is not necessarily a deep stage of sleep. It may be characterized as a central excitation accompanied by a peripheral behavioral depression. RPS does not belong in the wake-sleep cycle progression but rather appears to be an independent state.[4]

Gamma-hydroxybutyrate and alpha-chloralose

The cyclic diurnal nature of the wake-sleep cycle indicated the possibility of an endogenous mechanism. The search for the possible transmitter or modulator involved in such a system resulted in an interest in gamma-hydroxy-butyrate (GHB) in our laboratory. The observation that butyric acid produces sleep and at higher doses anesthesia, led Jouany et al[12] to examine derivatives of butyrate in an attempt to obtain more potent agents which were without ketogenic properties of the parent compound. The authors reported that GHB, which was derived from gamma-butyrolactone (GBL), was not ketogenic, induced a "sleep-like" state which was indistinguishable from natural sleep, and at higher doses induced general anesthesia (Laborit et al[13]). These authors utilized GHB as an anesthetic agent in several thousand neurosurgical cases without noting any untoward effects. Examination of anesthesia journals indicates that this compound is used in many European and Asian countries and there are over 200 clinical reports of its efficiency as an anesthetic agent. Bessman and Fishbein[14] have demonstrated the presence of endogenous GBL in the brain of the rat, pigeon, and man. They further noted an increase in these levels during GHB-induced anesthesia in the rat.

Experiments were undertaken in order to compare the so-called "sleep state" induced by GHB with natural sleep. In addition, several investigators[15–17] report a similarity in EEG activity between anesthetic doses of GHB and pentobarbital, thus a comparison of the actions of these two drugs was undertaken.

Results demonstrated the progression of several types of epileptiform EEG patterns induced by GHB (Fig 1B); *i.e.*, high frequency low voltage (alert pattern; desynchronization), 2½ cps intermittent hypersynchrony; 2½ cps continuous hypersynchrony; spiking with short 7–15 cps polyphasic bursts and periods of electrical silence; and a hypersynchronous high frequency generalized seizure. During the 2½ cps activity there were no overt signs of convulsion, but the animal manifested a fixed posture with dilated pupils, salivation, and inappropriate head and body movements suggesting a "catatonic like" and/or "hallucinogenic like" state; during the spiking there were myoclonic jerks and during the hypersynchronous high frequency bursts there were generalized convulsions. This behavior, when coupled with the continuous EEG epileptiform pattern, suggested that this drug has induced a state which is similar to generalized nonconvulsant epilepsy described by Gastaut.[18] This drug-induced state has several other features in common with generalized nonconvulsant epilepsy; namely, brief periods of induced arousal (during hypersynchrony), myoclonic jerks (during spiking), slight reduction of muscle tone (during spiking), and no apparent postictal depression except after generalized seizure.

There was no evidence that any of the EEG or behavioral patterns noted after GHB were in any way identical to those of pentobarbital.[5]

SUMMARY OF OTHER DRUG RESULTS

A comparison of the neurophysiologic effects induced by various drugs used to induce anesthesia, hallucinations, or excitation can be noted in Table 1. There are three basic types of behavioral responses to these agents, all inducing varying degrees of unresponsiveness; *i.e.*, inappropriate movements (hallucinatory), generalized seizures, and general

anesthesia. Electrically the hallucinatory state is characterized by hypersynchrony, the epileptoid state by spikes and/or generalized seizure waves, and the anesthetic state by a progressive flattening with burst suppression.

DISCUSSION

The progression of EEG changes noted following GHB suggests a continuum of electrical patterns similar to the stages induced by increasingly more potent CNS ex-

TABLE 1—*Comparison of effects induced by various drugs*

	Intermit. Hypersyn.	Cont. Hypersyn.	Inapprop. movement	Spikes with Elec. Sil.	Gen. Seiz.	Burst Suppr.	Gen. Anesth.
Pentobarbital	O	O	O	O	O	P	P
Halothane	O	O	O	O	O	P	P
Ether	P	P	P	O	O	P	P
Nitrous Oxide	P	P	P	O	O	O	O
Lysergic Acid Diethylamide	P	O	P	O	O	O	O
Mescaline	P	P O	P	O	O	O	O
Trichlorethylene	P	P	P	O	P	O	O
Phencyclidine	P	P	P	P O	P	O	O
Pentylenetetrazol	P	P	P	P	P	O	O
Alpha-Chloralose	P	P	P	P	P	O	O
Gamma-hydroxy-butyrate	P	P	P	P	P	O	O

P = present.
O = absent.

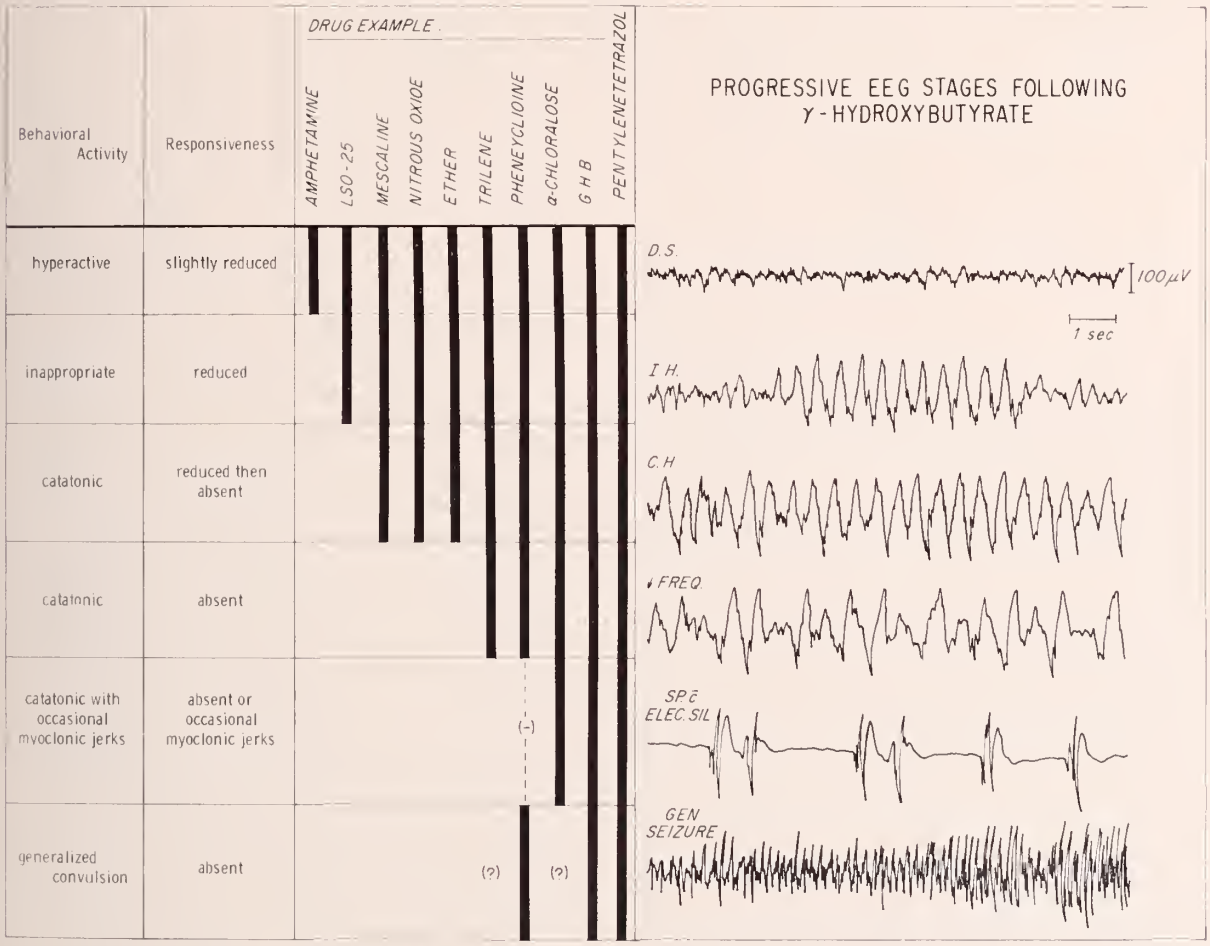

Fig. 1—Behavioral activity, responsiveness, EEG stages following γ-hydroxybutyrate (GHB) and a representation of the progression of effects induced by various drugs. Desynchronization (D.S.), intermittent hypersynchrony (I.H.), continuous hypersynchrony (C.H.), reduced frequency of hypersynchrony (↓ frcq.), spikes with electrical silence (Sp. & Elec. Sil.), and generalized seizure (Gen. Seizure). Spikes with electrical silence rarely noted following phencyclidine and generalized seizures reported to occur following α-chloralose and trichlorethylene were not observed in our studies.

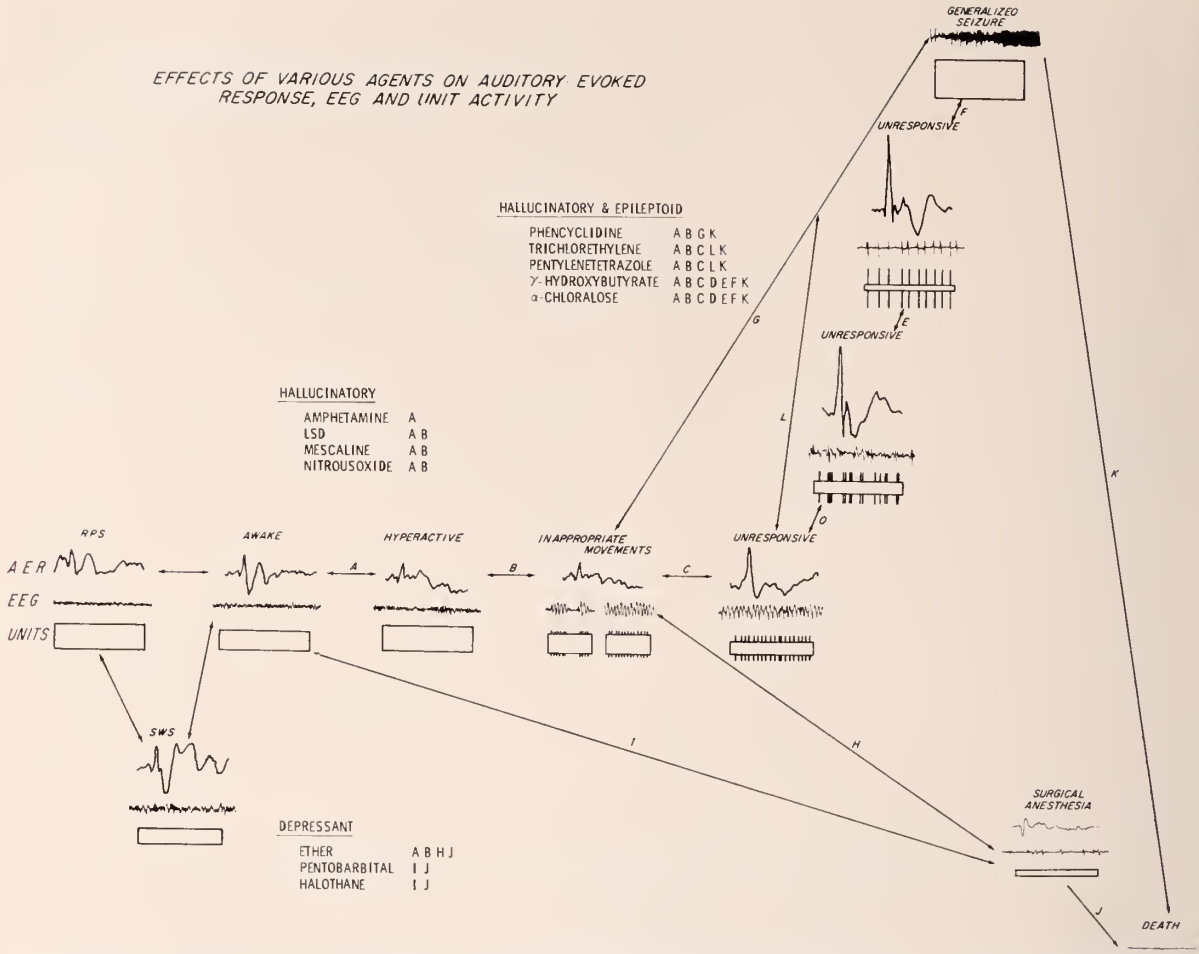

Fig. 2—Proposed continuum of CNS excitation and depression based on the action of the agents listed. The auditory evoked response (AER), and reticular unit activity are not discussed in this presentation. The letters following each agent indicates participation in the corresponding progression.

citant agents (Figs 1 & 2). This GHB continuum is as follows: desynchronization, intermittent hypersynchrony, continuous hypersynchrony, spikes, spikes with electrical silence, and generalized seizure. The drugs representative of these stages are as follows: amphetamine (desynchronization); mescaline, LSD, phencyclidine, GHB, alpha-chloralose, ether, and trichlorethylene (hypersynchrony); phencyclidine, pentylenetetrazol, GHB, alpha-chloralose and trichlorethylene (all states up to generalized seizures).

With the exception of pentobarbital and halothane all of the agents examined fit at least part of the GHB continuum. Phencyclidine, trichlorethylene, and alpha-chloralose induce EEG patterns which are similar to GHB; during ether induction the animal passes through a hypersynchronous state (Stage II) prior to progressing on to general anesthesia; and nitrous oxide induces only the hypersynchronous EEG pattern. Following hypersynchrony either no progression (nitrous oxide), an epileptoid (phencyclidine, alpha-chloralose, pentylenetetrazol, trichlorethylene, or GHB), or anesthetic (ether) state can ensue. Pentobarbital and halothane do not pass through a hypersynchronous state but rapidly progress into deepening stages of general anesthesia.

These studies suggest a progression of changes to different levels of excitability or depression, some agents sharing initial properties with drugs of opposite action for example, ether and phencyclidine. Further, if a continuum of excitability is characterized by the GHB EEG then it appears that a hallucinatory state (aura) can precede the generalized convulsant state, can precede the anesthetic state (Stage II delirium), or can be regarded as an anesthetic state itself (nitrous oxide—Stage II). Any of the above

mentioned states will satisfy the basic requirements for anesthesia since any agent which induces a loss of responsiveness and amnesia and can be used as an anesthetic agent. Thus, while drugs such as nitrous oxide, phencyclidine, trichlorethylene, GHB, and alpha-chloralose are listed as anesthetic agents implying that they are CNS depressants, they all are in fact CNS excitants capable of inducing hallucinatory and/or generalized seizure activity. The interpretation of the mode of action of these agents in these cat studies suggests that their usefulness as general anesthetics should be carefully reviewed.

Perhaps what actually bears closer scrutiny and revision is the definition of properties of a general anesthetic agent. It is remarkable that such a large group of agents are considered to belong to one class of agents when in fact they belong to a completely opposite group. It is possible that certain types of surgical procedures may be more advantageously performed under the influence of these agents. The final decision as to whether hallucinatory and epileptoid agents belong in the armamentarium of the anesthesiologist is not within our province to judge. Our aim is only to point out that these different types of agents do exist. It is our hope that the clinicians will critically evaluate the actions of these agents and come to their own scientific conclusions.

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No. 1 of a Series

Editor:

HARRY BECKMAN, M.D.

Houghton Fellow in Clinical Research and Consulting Physician, Columbia Hospital

COLUMBIA HOSPITAL, MILWAUKEE

These are recorded reports, which have been edited, of conferences held on Tuesday mornings, 8–9, involving participation by members of the staff of the hospital, interns, residents, and guests. They will be published in a selective manner periodically in the WISCONSIN MEDICAL JOURNAL.

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FRANCIS F. ROSENBAUM, M.D.
JAMES E. MAY, M.D.

Dr. Donald M. Willson: The conference this morning is concerned with a therapeutic dilemma that really hinges upon a diagnostic one. Doctor Corcoran, will you present the case report?

Dr. William Corcoran, Jr. (Resident in Medicine): The patient, a 45-year-old Negro woman, who had been aware of a small goiter since June 1965, had been asymptomatic until about 7 months prior to admission in the late fall of 1966, when she had noted that her menstrual flow began to slow up and then finally cease. In the summer of 1966 she became aware of nervousness, intolerance to heat, sweating, occasional diarrhea, fatigue, and hot flashes. About 2 months prior to admission the goiter began gradually to enlarge, but there were no pressure symptoms or dysphagia. Her hair, however, became finer and more straight, and there had been a 17-pound weight loss during about 4 months. The patient's own history was noncontributory, but she had 2 sisters with toxic goiters, one in her thirties and the other in her forties. The mother had died in her thirties of a cause unknown to the patient.

Temperature was normal; pulse rate, 108, rhythm regular; blood pressure 130/60 mm Hg; weight, 123 lb. The skin was warm and moist; deep tendon reflexes, very brisk. There was a diffusely enlarged goiter; nodular, and feeling somewhat firm. There was no anemia on admission, white and differential counts were normal; cholesterol, 146 mg/100 ml; protein-bound iodine, 13.5 mcg/100 ml; the I^{131} uptake was 78%, conversion ratio 73% with saliva ratio of 1; the scan showed a diffusely enlarged nodular gland with an increased uptake in the nodules. The glucose tolerance test revealed a peak of 233 at 1 hour with a positive glycosuria, and a 3-hour 180 mg/100 ml level with no sugar in the urine. The Papanicolaou smear was negative. Several electrocardiograms were taken during the hospital stay because of complaints of precordial chest pain; these will be discussed later, but during the time they were being taken there were no changes in the sedimentation rate, enzymes, or the white blood cell count and there was no fever. The chest x-ray was normal. Impression at this point: hyperthyroidism.

Doctor Willson: Here then is a patient with the clinical picture of thyrotoxicosis and a large nodular goiter. Doctor Chamberlain, since this is your case do you wish to begin the discussion?

Dr. John O. Chamberlain: I shall only remark upon the patient as she presented and what my thoughts were. Actually, Doctor Lillie called me on the phone one afternoon and said he had a patient with hyperthyroidism that he would like me to care for. I suggested that, as an internist, I might well be inclined to recommend radioiodine for therapy rather than surgery. With his well known tongue-in-cheek manner he retaliated by suggesting that I withhold decision until after I had seen the patient. Indeed, the thing of particular interest proved quickly to be the gland itself.

Clinically the patient appeared to be typically hyperthyroid in every way except for the eye signs—she was tremulous, warm, had tachycardia and weight loss, 2 sisters with toxic goiters; the story was complete. But the gland was not quite right. It was 2+ to 3+ enlarged, to the extent of about 50 gm,

I should say, and somewhat irregular. The region of the left lateral lobe was quite firm and much more indurated than one feels in the usual case of nodular goiter; certainly it had a quite different feel from that of Graves' disease. I pay a great deal of attention to the feel of the gland in considering the diagnosis of hyperthyroidism—being interested not only in finding a goiter, which is usual in hyperthyroidism, but more especially in feeling the consistency of the gland.

Doctor Beckman was unaware of the special issues of the WISCONSIN MEDICAL JOURNAL *being prepared to honor him and Doctor Quick when he submitted this article which is the first in a series of articles Doctor Beckman has planned and written especially for the* JOURNAL. *It seemed appropriate to include this first article in these issues.*—EDITOR

I recall quite vividly when Doctor Robert Byrne and I were over in Ann Arbor some time ago, getting ready for our isotope laboratory setup here, we heard someone ask Doctor Beierwaltes the question: "If you had all the various means at your disposal to determine hyperthyroidism, but could choose only one, what would you select as the single thing most helpful in making the diagnosis?" He thought for a moment and said, "Consistency of the gland." I am sure he would want to qualify that statement in many instances, but still it does sharply emphasize the significance of the feel of the gland in this disease. It has a certain feeling of crispness to it, this gland of hyperthyroidism. And the gland that our present patient presented was not noticeably crisp; furthermore, the lateral portions of it were very firm.

With this finding, I immediately abandoned the thought of radioiodine therapy and considered it necessary to prepare the patient for surgery, since it appeared that our differentiation would have to be between malignancy and Hashimoto's thyroiditis. The electrocardiographic changes, referred to by Doctor Corcoran, were rather startling, limited entirely to ST and T wave changes, but they were significant and they were changing. So we kept her in hospital for 2 or 3 weeks, and the EKG abnormalities had returned practically to normal prior to the surgery. After that she has had no cardiac symptoms whatsoever.

Interestingly, her thyroid antibody test was positive in significant dilution, making the diagnosis of Hashimoto's thyroiditis a good bet, but as you know, it may be elevated considerably in some cases of hyperthyroidism and even thyroid malignancy. Doctor Cerletty will discuss this in more detail later. This patient certainly presented a very unusual combination of maladies, but actually Doctor Gale Mendeloff and I have seen one similar case in this hospital.

Doctor Willson: Doctor Chamberlain has described an unusually hard, indurated, nodular gland in this patient with thyrotoxicosis. Doctor Lillie will discuss the problem from the diagnostic and surgical standpoints.

Dr. Richard H. Lillie: Yes, I have had the good fortune not only to feel but actually to see and remove this gland. The fortunate thing about it from the patient's standpoint was the fact that Doctor Chamberlain has alluded to, namely, that it did not feel like any toxic gland I had ever examined. If you will go over the reported series of surgical specimens in Hashimoto's disease, you will find that the incidence of toxicity in such glands is extremely low. In Crile's series there were no such cases at all. Doctor Chamberlain is certainly very fortunate in having seen Hashimoto's disease complicated with thyrotoxicosis in two instances. I was frankly puzzled by this case when I first encountered it. Here was a lady who was obviously toxic—you could see it from across the room—and yet she had a gland that did not resemble any toxic one that I had ever seen.

The problem in Hashimoto's disease, so far as operative surgery is concerned, relates chiefly to accomplishing something cosmetically in some cases and relieving tracheal compression in others. It is diagnosis that presents the chief difficulty. The gland usually enlarges steadily and it often has areas that are firmer than others, and hence there is confusion between the Hashimoto gland and that of multinodular goiter. I tell the surgical residents repeatedly that the most helpful thing to me in distinguishing between Hashimoto and the multinodular goiter is the feel of the gland. In Hashimoto, if you feel around the lobes you will find them usually extending far to the side, and they have a sharp edge. This edge is often quite smooth and you can get your fingers behind the gland; you can lift it forward with your thumb on it in front—it's a very distinctive

feeling. In a multinodular goiter, on the other hand, you are much more likely to find asymmetric nodules along the back side of the lobe, and you can't move it forward as easily. This difference has been most helpful to me.

You are all familiar with the accounts of establishing the diagnosis with needles. Well, there are needle surgeons and there are non-needle surgeons. I happen to be a non-needle surgeon. I do not like people sticking needles in nodules in the thyroid gland, for the one malignancy that is transgressed with a needle will more than lose for you all the advantage that might be gained through reassuring a patient about a benign lesion, and you may miss a malignant area within the nodule.

The gland at operation is found to be firm and it may have an appearance indistinguishable from that of a carcinoma. But as you palpate it or squeeze it between your finger tips you find that it has the rubbery firm feeling that is characteristic of Hashimoto's disease. I try to impress upon our residents the importance of recognizing this distinction because it enables you to predetermine what you're going to do, rather than localizing the lobe, getting halfway through, and then realizing that you're going to do a total thyroidectomy to take out the suspicious area. What we did in this case was to remove about four-fifths to seven-eighths of the gland—I estimate that there are 4 or 5 gm left on each side—in an intracapsular fashion, and then utilized the outside of the capsule approximated to the trachea for hemostasis. In this way we avoided the two things that are most feared in thyroidectomy; namely, injury to the recurrent laryngeal nerves and the production of hypoparathyroidism.

Doctor Willson: Thank you, Doctor Lillie. Fortunately, most patients with Hashimoto's thyroiditis are not as complicated as this one and can be treated medically without benefit of histologic diagnosis. When a biopsy is desirable, however, and with due regard for its hazard when an unexpected carcinoma is encountered, the needle is a recommended method of establishing the histologic diagnosis. Doctor Rosenbaum, you saw this patient in consultation. Would you care to say anything about the case from the cardiologist's standpoint?

Dr. Francis F. Rosenbaum: The patient had quite remarkable electrocardiographic changes that were most pronounced when she was most hyperthyroid. As she advanced in the preparation for surgery these changes lessened and ultimately became normal just before the operation. The question of the etiology of such EKG alterations is a very interesting one; so far as I am aware, the cardiac complication in hyperthyroidism is usually attributed to associated valvular or atherosclerotic disease. Few people have felt that hyperthyroidism per se is responsible for the congestive heart failure or the auricular fibrillation that so commonly complicates the picture. It is true that oxygen consumption is greatly increased in patients with hyperthyroidism, and this at a time when there is considerable reduction in coronary artery resistance and the metabolic levels throughout all tissues are vastly increased. But whether it is possible to have a sufficient disproportion between the myocardial demands and the coronary circulation to produce the kind of EKG changes we saw in this patient as a secondary manifestation, I really do not know. However that may be, our patient had rather pronounced changes in the RST segments and she had very distinctive terminal inversion of the T wave. This was certainly not a normal EKG, but I believe the records made in Doctor Chamberlain's office some time after the patient left the hospital showed that the abnormalities had completely disappeared.

Doctor Chamberlain: That is true.

Doctor Willson: Thank you, Doctor Rosenbaum. Doctor May will describe the pathologic findings.

Dr. James E. May (Resident in Pathology) : The laboratory received the separately submitted right and left lobes of the thyroid. These averaged 5 x 3 x 3 cm, and their aggregate weight was 47 gm. The tissue was abnormally firm, and the cut surface was a uniform pale-tan, with small interlacing bands of fibrous tissue. The histologic appearance was compatible with that of a hyperfunctioning gland that had been treated with iodine and antithyroid medication: the follicles varied moderately in size and were lined by columnar to tall cuboidal epithelium with occasional papillary projections; some were devoid of colloid, while others contained abundant eosinophilic colloid. There was also extensive fibrosis and lymphocytic

infiltration of the gland, with occasional atrophy of follicles and degenerative changes of follicular epithelium, the latter consisting of nuclear ballooning and cytoplasmic eosinophilia. The histologic features were those of chronic lymphomatous thyroiditis, or Hashimoto's thyroiditis. No evidence of malignancy was seen.

Doctor Willson: Thank you, Doctor May. This appears then to be a case of thyrotoxicosis associated with histologically proven Hashimoto's thyroiditis. Doctor Chamberlain, we would be grateful for a description of the other case of thyrotoxicosis associated with thyroiditis you spoke of having seen with Doctor Mendeloff.

Doctor Chamberlain: This was a girl who presented about two and one-half years ago. Doctor Mendeloff had removed most of the gland, not only for cosmetic purposes but also because he was concerned that there might be malignancy present. The diagnosis proved to be Hashimoto's disease, and he asked me to take care of the patient medically following the initial surgery. She was placed on an average of about 3 gr of dessicated thyroid daily, which is usual therapy in such cases, and did quite well for about 6 months. Then the remnant of the right lobe of the gland enlarged to about the size of an egg, and toward the end of this period of enlargement exophthalmos became apparent.

At about this time reports began to appear of exophthalmos alone without hyperthyroidism in patients with Hashimoto's disease. Of course all of us are aware that exophthalmos may occur 10 or even 20 years before the actual overt hyperthyroidism in Graves' disease, or that it may not appear until 5 or 10 years after the actual hyperthyroidism is established, or that it may never appear at all. But I was also interested to learn from my reading, and also to experience in this actual patient, that it may also occur occasionally in a patient with Hashimoto.

PBI was about 8.5 and her uptake was around 45%, and she was not clinically hyperthyroid. She was a nervous girl but she wasn't clinically, overtly hyperthyroid. However, she did have a positive Werner's suppression test [the failure to accomplish a striking decrease in radioiodine uptake when sodium levothyroxine (Synthroid [T-4]) or sodium L-triiodothyronine (Cytomel [T-3]) is given]. In other words, she had exophthalmos and both Graves' disease and Hashimoto's disease without overt hyperthyroidism.

Doctor Willson: Thank you, Doctor Chamberlain, for complicating the picture still more for us by adding this patient with exophthalmos and thyrotoxicosis as a late association with Hashimoto's thyroiditis.

We have the privilege this morning of having with us Doctor Cerletty, who is Assistant Director of Medicine at the Milwaukee County General Hospital. Doctor Cerletty, perhaps you should now tell us something more about this fascinating subject of Hashimoto's disease.

Dr. James M. Cerletty: Hashimoto's disease may be seen at any age but it is most common in the fourth or fifth decades, and it occurs almost exclusively in females. It is also seen more commonly in people with family history of goiter and has actually been reported in uniovular twins. Sometimes the patient complains of a vague fullness in the neck and slight pain, and there may even be dysphagia, but almost invariably she is asymptomatic and her only complaint is that goiter has been present for a few months or a few years and is slowly increasing.

The coincidence of hypothyroidism with Hashimoto's is variously estimated at 20% to 80%, but most of us feel that it is very likely to develop slowly during a period of several years. In any case, when we see a patient who has goiter *and* hypothyroidism, the diagnosis of Hashimoto's thyroiditis should be strongly considered. Very few other conditions commonly seen will produce this combination. The enlargement of the gland tends to be diffuse, although frequently one lobe may be larger than the other and many patients present an enlargement of the centrally located pyramidal lobe; this latter finding creates something of a problem in that it may raise the question of a solitary nodule. Satellite lymph nodes can sometimes be felt, and especially the so-called Delphian lymph node right above the thyroid isthmus.

In "explaining" Hashimoto on the basis of an autoimmune mechanism, it has been postulated that there is some initial transient damage to the thyroid gland, with resultant release of material into the circulation that stimulates antibody formation. Circulating antibodies to several thyroid gland constituents have been demonstrated in patients with

Hashimoto's disease but, unfortunately for our present concern, with other thyroid disorders as well.

Serologic tests for these antibodies include the gel diffusion test, the tanned-red-cell agglutination test, and the latex agglutination test. The complement fixation tests and the cytotoxic activity test measure antibodies to thyroid intracellular microsomes, and the fluorescent antibody technique has been adapted to measure all of these and in addition a couple of other antigens, a nuclear antigen and a colloid antigen. The tanned-red-cell agglutination test is by far the most sensitive of the tests, but perhaps a little bit too sensitive. The gel diffusion test is the least sensitive, but probably the most significant when it is positive. In Hashimoto's disease we usually find a higher incidence of strongly positive reactions to these tests than in any of the other thyroid disorders, but unfortunately we also occasionally see cases in which there is a negative antibody titer, even by the most sensitive methods. The next most common causes of strongly positive tests are occasionally seen in thyrotoxicosis and in nontoxic nodular goiters, and in cancer of the thyroid there are positive reactions in about 30% of the cases.

Now actually the only way we can make the diagnosis of Hashimoto's thyroiditis with certainty is through observation of the characteristic pathologic changes. These are oxyphilic transformation of the thyroid acini and lymphocytic infiltration of the follicles, fibrosis, and infiltration with plasma cells. With necrosis of the thyroid tissue, thyroglobulin and related compounds spill out into the circulation. These components are measured in the PBI, but they are not soluble in butanol and therefore not measured in the BEI. So it might be helpful in some cases to have a BEI on a patient just as another confirmatory test.

In all of a series of 101 cases with biopsy-proven Hashimoto's thyroiditis at the Mayo Clinic (W. M. McConahey, et al. *Journ. of Clin. Endocrin. & Metab.*, 21:879, 1961), the difference between the PBI and the BEI was greater than 1 microgram per cent, while in 40 patients with multinodular goiter, a difference greater than 1 was seen in only 10% of instances; and in none of these latter cases was the difference greater than 2 micrograms per cent, while it had exceeded this figure in nearly half of the Hashimoto cases.

The radioiodine uptake test in the early phases of Hashimoto has been occasionally reported to be elevated, but after the disease has progressed somewhat the usually reported values are low or normal; and of course with further progression the value drops down to practically zero. The impaired ability of the gland to convert the trapped inorganic iodine into organic iodine can also be demonstrated by the so-called flushing test with thiocyanate or perchlorate.

The publication of several series of observations with rather discordant findings has made it impossible to state with assurance precisely what the incidence of malignancy is in Hashimoto's disease, but certainly it is extremely low. Failure to discover carcinoma, or even discovery of Hashimoto's thyroiditis in the needle biopsy specimen, in no way excludes the possibility of carcinoma elsewhere in the gland and thus may lead to false complacency. Any lesion in the thyroid suspected of being malignant should be removed at open biopsy and a frozen section made for diagnosis, as was very properly done in the case we are considering here this morning.

Doctor Willson: Thank you, Doctor Cerletty. Are there any questions or observations that anyone wishes to make?

A Physician: What is the coincidence of pernicious anemia and Hashimoto's disease?

Doctor Willson: Hashimoto's has been recorded in association with many other so-called autoimmune disorders, Addison's disease, rheumatoid arthritis, pernicious anemia, and other maladies. Recently at the Johns Hopkins Hospital, Mulhern's group (*Lancet* 2:508, Sept. 3, 1966) searched for these associations in 170 clinically detected and histologically confirmed cases of the disease. Whether a significant clinical association between pernicious anemia and this type of thyroiditis occurs was not clear. In fact, possible associations with Hashimoto's disease were suggested by their analysis only for rheumatoid arthritis and chronic false-positive tests for syphilis; for systemic lupus erythematosis, an association was equivocal at best.

A Physician: The presence of serum antibodies per se or of lymphoid tissue in the thyroid gland does not specifically account

for the disorder because these things occur in other thyroid maladies. Furthermore, in most of the so-called autoimmune disorders, the tissue damage has usually been thought to be associated with decreased serum complement. I wonder if there are any data on either the serum levels of complement in these Hashimoto patients, or is there any evidence of the binding of complement to thyroid tissue? If there were findings of this sort it would seem to be rather convincing evidence of an autoimmune reaction and that the antibodies are not merely camp-followers.

Doctor Cerletty: The binding of complement evidently has been demonstrated through a fluorescent antibody technique in some instances, but I do not know the extent.

Doctor Willson: Actually we do not really know the true incidence of Hashimoto's disease since the diagnosis was only made at necropsy, or on a surgical specimen, until relatively recently. Nowadays we are diagnosing these cases clinically and I have the impression that at the Mayo Clinic they are now seeing more Hashimoto's disease than Graves' disease, although of course their cases are a highly selected group. There is a feeling that much adult hypothyroidism is the end-result of previous asymptomatic thyroiditis.

A Physician: In most instances Hashimoto's disease is medically diagnosed and I do not think we need to go to the open biopsy very often. Of course, I agree that when a serious question of diagnosis arises, this is the proper course to take. I should like to comment on the surprising frequency of this malady in young children, particularly in young girls. I have seen two or three children under 10 years of age, and there is now evidence that a relatively high proportion of goiters in young girls is in fact Hashimoto's disease. Of course, early diagnosis and treatment with thyroid hormone are particularly important in this age group.

Doctor Willson (summarizing): We have had presented this morning two cases of Hashimoto's disease. In one, the choice of therapy was determined by appreciation of the differential features of the thyroid gland itself; in the other, there was the rare occurrence of exophthalmos in a patient who had Hashimoto's disease but not thyrotoxicosis.

FOR YOUR INFORMATION . . . from the Wisconsin State Board of Health

TUBERCULOSIS IN WISCONSIN

Fewer new cases of active tuberculosis were reported in Wisconsin during 1966 than in 1965, according to Dr. Josef Preizler, director of the Division of Tuberculosis Control of the State Board of Health. There were 480 new cases in 1966 and 560 the previous year.

The biggest decline took place in the city of Milwaukee. Only 162 new cases of tuberculosis were reported in 1966 as compared to 201 in 1965. There were only 21.0 cases per 100,000 population last year whereas the rate had been 26.3 in the preceding year.

For the entire state, the rate of TB infection was 11.5 per 100,000 population in 1966. It had been 13.5 in 1965. The rate for rural areas of the state was 6.3 per 100,000 in 1966 as compared to 6.5 the preceding year. The improvement in the overall state rate was due almost entirely to the decline in cases in the city of Milwaukee.

Of the 480 new cases 301 were men patients and 179 were women. Approximately the same ratio had been experienced the year before. It was also noted that among both men and women about half of the patients are aged 55 or older. About 96% of the patients had sanitarium care.

There were about 120 holdover active cases to make a total of 600 active cases in 1966. Public health authorities have a policy under which they contact a tuberculosis patient for 5 years after he has been listed as cured. At the present time the state is following the medical progress of about 2,500 one-time tuberculosis patients. An even closer surveillance and of longer duration, said Doctor Preizler, is the follow-up given these one-time patients by their personal physicians and by the sanitarium outpatient departments at which they may have been treated.

Further declines in the rate of tuberculosis infection can be expected since the start of preventive programs.

NEW HEART FILM

A new film "Heart Sounds and Murmurs" has been added to the Wisconsin Heart Association library.

The origins of heart sounds in the heart are explained in terms of faster or slower moving of liquid confined within elastic walls. The authors demonstrate physical factors which condition blood flow and affect the intensity, direction and quality of sound related to flow.

Use of this film can be obtained by writing the Wisconsin Heart Association Film Library, 4431 West North Avenue, Milwaukee, Wis. 53208.

Therapy with Amphotericin B

By HELEN A. DICKIE, M.D.
Madison, Wisconsin

■ AMPHOTERICIN B, an antibiotic derived from a strain of streptomyces nodosus, has been used for 10 years. It has proved efficacious in the treatment of systemic mycosis. Unfortunately, it is a relatively toxic drug which requires full recognition of its potential hazards. If those are understood and properly managed, patients who would otherwise die from fungus infection can be successfully treated and suffer no serious residual damage.

Amphotericin B should be diluted in a 5% dextrose solution and given intravenously over a four to six hour period. The initial dose should be small, about 5 to 10 mg. The patient should be observed closely and if chills and fever occur, the infusion should be slowed or stopped depending on the severity of the reaction. The dose is gradually increased over a period of several days until the level of 1.0 to 1.5 mg per kg of body weight is achieved. This represents the usual maximum amount to be given as a single intravenous injection. If this therapeutic range it not achieved because of immediate type reactions of chills and fever, the use of prednisone, 20 to 30 mg orally per day, usually eliminates these side effects. Antipyretics and antihistamines may be used, but they are not very effective. Thrombophlebitis, a frequent problem, can be controlled by the addition of heparin to the 5% dextrose solution containing amphotericin B.

Blood urea nitrogen should be determined daily and if it rises above 30 mg per 100 ml, the dose of amphotericin B should be reduced and the interval between the injection lengthened to two or three days. Serum potassium levels should be checked every three to four days and if a potassium deficiency arises, it should be corrected with oral replacement.

The reasons for the above mentioned precautions are best understood by a realization of the action of amphotericin B. This antibiotic causes increased permeability of the cellular membrane of the yeast cells, as well as the human cells, with the resultant leakage of the essential intracellular constituents. It appears probable that the chemotherapeutic and the toxic effects of amphotericin B are manifestations of a common mechanism of action.

Renal dysfunction is the most serious and the most persistent of the toxic effects. Decreased renal function occurred in 80% of the treated patients in one study, and the abnormalities may persist long after the therapy is discontinued. The degree of renal damage is related to the total dose of amphotericin B. Histopathologic examination of the kidney has revealed tubular damage and calcification. In man, glomerular filtration and effective renal plasma flow have decreased with the use of the drug. Anemia due to reversible bone marrow damage is common but rarely requires treatment. Symptomatic hypokalemia, increased urinary excretion of potassium and sodium, and hypomagnesemia have been documented. The immediate reactions during the administration of the drug are fever, chills, nausea, vomiting, and headache.

The selection of patients for therapy should be carefully made. Except in very acute and life-threatening situations it is recommended that treatment be withheld until the diagnosis is established by demonstration of the fungus by appropriate microscopic and cultural techniques. Lacking the actual demonstration of the fungus, complement fixation test plus the clinical picture may be utilized in coccidioides immitis and histoplasma capsulatum infection. The drug

Doctor Dickie is Professor of Medicine, University of Wisconsin Medical School; and Chief-of-staff, University Hospitals.

COMMENTS ON TREATMENT

Presented through the cooperation of the Department of Phormacology, Marquette University, Milwaukee, ond the Department of Medicine, University of Wisconsin, Madison

HAROLD F. HARDMAN, M.D., Ph.D., Co-Editor
Marquette University School of Medicine

OVID O. MEYER, M.D., Co-Editor
University of Wisconsin Medical School

has been used successfully in blastomycosis, histoplasmosis, coccidioidomycosis, cryptococcosis, sporotrichosis, candidiasis, mucromycosis, and disseminated as well as progressive pulmonary aspergillosis.

It is important to recognize that primary infections with histoplasma capsulatum and coccidioides immitis rarely result in a serious problem and they are self-limited. Therefore, these patients should not be treated until there is some evidence of dissemination. Blastomycosis can be treated with hydroxystilbamidine but amphotericin B is probably a more effective drug. Any recognized lesion of blastomycosis should be treated. Sporotrichosis usually responds to iodides, and amphotericin B should be reserved for those who fail to respond to iodide therapy.

Amphotericin B does not cross the blood brain barrier readily. Therefore, in meningitis, usually seen only in coccidioides immitis and cryptococcal infections, amphotericin B must be used intrathecally in 1 to 5 mg dose. In fact, in chronic coccidioidal meningitis, intraventricular injections are reported to be the treatment of choice for the long-term management.

The total dose should be held to a minimum. One gram of amphotericin B gives excellent results in the majority of patients with blastomycosis, histoplasmosis, as well as in most patients with coccidioides immitis, and cryptococcal infections that have not developed meningitis. Above 2 or 3 gm, permanent renal damage is almost certain. It is difficult to be dogmatic about the exact amount of amphotericin B necessary to control any fungus infection. Adequate surgical drainage or resection of persistent cavities should be utilized if necessary. Improvement continues after therapy is stopped. There is little reason to believe that drug resistance of the fungi develops so that the drug can be administered if there is a relapse. In our experience we have seen no relapses in several patients with serious disseminated histoplasmosis treated with a total dose of one gram. Several severe blastomycotic lesions have responded and remained well after this same dose. Three patients with cryptococcal infection, including one with meningitis, have also been controlled with one gram of amphotericin B. Three coccidioides immitis infections have responded and remained well with the same amount of drug.

In summary, amphotericin B is the treatment of choice in systemic mycotic infections. With the proper knowledge of the undesirable reactions and management of these, the treatment is effective and no serious residual damage to the kidneys need occur.

POSTOPERATIVE HEMORRHAGE AND THE TETRACYCLINES

WALTER D. SCHWINDT, M.D. and WILLIAM KISKEN, M.D., University of Wisconsin Medical Center, Madison: *The American Journal of Surgery,* June 1967.

Tetracycline toxicity has been reported in the pregnant as well as the nonpregnant patient. This has almost always been associated with the intravenous administration of excessive doses of tetracycline. Most of the fatal cases have had gastrointestinal hemorrhage as well as severe liver damage.

Two cases of suspected tetracycline toxicity are presented. Both patients had obstructive jaundice of short duration and postoperatively received excessive intravenous tetracycline. Despite surgical relief of their biliary tract obstruction the degree of jaundice increased, and their course was complicated by massive gastrointestinal hemorrhage. Derangement of clotting factors was found. Both patients continued to deteriorate and died. It is felt that excessive doses of tetracycline caused additional liver damage and may have been a factor in the etiology of hemorrhage.

Doctor Schwindt is currently spending a year in the thoracic surgery clinic of the University of Lund in Malmö, Sweden.

RESEARCH SUPPORT APPLICATIONS INVITED BY HEART ASSOCIATION

Applications from research investigators for support of studies to be conducted during the fiscal year beginning July 1, 1968, are now being accepted by the American Heart Association.

Sept. 15, 1967, is the deadline for submitting applications for Established Investigatorships, Advanced Research Fellowships, Visiting Scientists and British–American Research Fellowships.

Applications for Grant-in-aid should be submitted by Nov. 1, 1967. Grants-in-aid are made to experienced investigators to help underwrite the costs of specified projects, such as equipment, technical assistance and supplies.

The Association also appoints a limited number of investigators, of unusual capacity and widely recognized accomplishment, as Career Investigators, assuring them of financial support throughout their careers. These awards are made by the Association's Board of Directors on recommendation of the national Research Committee and *not by application.*

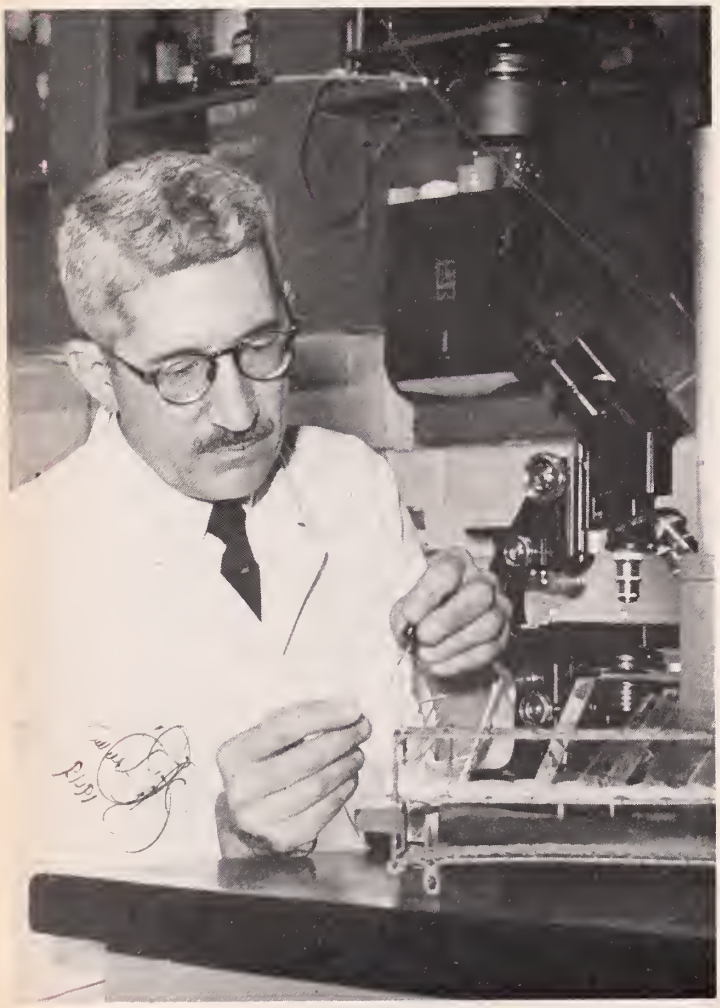
Application forms for research awards may be obtained from the Director of Research, American Heart Association, 44 East 23rd Street, New York, N. Y. 10010.

The Physicians' Counselor . . .

A Tribute to Harry Beckman

F. M. BERGER, M.D., Cranbury, New Jersey

THERE HAVE BEEN few writers on medical subjects during the recent past who have had a greater influence on the thinking and actions of practicing physicians than Harry Beckman. His numerous books and publications have established him as the authority in the field of practical therapeutics. Although a pharmacologist and laboratory scientist by vocation, he has had a profound and salutary influence on therapeutics. He understood that after a disease has been diagnosed, good medical treatment must be based primarily on a sound knowledge of pharmacology and a deep understanding of human nature. Harry Beckman by his writing has taught us both.



I am sure that many physicians the world over who attended medical school since the early 1930s have greatly felt his influence. I still clearly remember what a help it was to have Harry Beckman's "Treatment in General Practice" available when I first came into contact with patients as a medical student. Like most young men who go in for medicine, I wanted to be sure that all that was known in the way of treatment would be done so that my patients would not suffer because of my ignorance. Hary Beckman's "Treatment in General Practice," which first became available in 1930 and which has had many editions since, was invaluable in this connection. The importance of this volume to many young physicians is difficult to overrate. This book, in an intelligent, concise and critical fashion, supplied answers to the questions most often asked by the practicing physician: How can I help this patient? Is there perhaps a treatment I haven't heard of that should be tried? What kinds of treatment must I not use lest I harm him? There was just one book to turn to for answers to these questions and that was Beckman's "Treatment." It was respected and consulted not only because of its encyclopedic nature, but also because of Harry Beckman's presentation. It not only reported what had been claimed but also advised what should be tried and what should not be tried and for what reasons. An added attraction of the book was Harry Beckman's style. Although his directions were unmistakable, they were expressed in a manner that gave the reader the feeling that he and not the author was making the decisions. This is the feeling physicians like to have.

Harry Beckman is one of the great educators of physicians of our generation. He encompasses every attribute an educator must have to affect those who come to him for enlightenment. First, he is learned. When listening to him or reading his books, it becomes very obvious that there are very few things he has not heard about and has not thought about. Second, he is modest. He states his point of view but he does not force you to accept it. He presents the rationale and common sense argument and leaves it up to you to act in any way you may feel would be best. Third, he is entertaining. When reading the book it becomes clear that to know a lot is fun, and to know more is more fun, and so you cannot afford to stop accumulating further

Doctor Berger is President of Wallace Laboratories.

knowledge. Many of the attrihutes of his personality come through clearly when reading his books: wisdom, caution, character, intelligence, industry, outspokenness, respect for human life and dignity, modesty, humor and, above all, a desire to be of assistance if needed, for no better reason except that this is the thing to do.

Physicians engaged in the practice of medicine can be broadly divided in two groups according to their fundamental approach to their art and science. The one group stresses the fundamental importance of diagnosis, takes delight in the knowledge of pathological anatomy, and believes that most remedies are glorified placebos. This was the attitude of the Viennese School of thought so influential in the area of the old Austro-Hungarian Empire since the 1890s. The other group, represented by attitudes of most physicians in France and Germany, considered therapy the ultimate goal of medicine. Diagnosis was important because it led to the correct treatment. This group had faith in remedies, sometimes too much uncritical faith, but they were optimistic for the future. They refused to accept the skeptical attitude of the Austrian savants and made important contributions to therapeutics. Consider for a moment the stream of new and valuable remedies that were discovered in Germany and France since the late 1880s: aspirin, phenacetin, the arsphenamines, the antimalarials, the sulfonamides, the local anesthetics, the anti-trypanosome agents, the antihistaminics, the anti-tubercular agents, the oral antidiabetics, synthetic analgesics, neuroleptics, etc. All that sphisticated and skeptical Austria could offer during this period was the discovery of psychoanalysis.

Harry Beckman was aware of these two broad divisions. His publications combined what was best in the two schools. He felt that the advances made in Germany and France in the field of new drugs must be continued and amplified and that, at the same time, each new remedy as it is introduced must be carefully evaluated so that one could be sure that it would do what is claimed for it. All this by now has become the official doctrine and Harry Beckman and his writings played an important part in bringing it about.

The years have been good to Harry Beckman. Instead of simply revising his "Treatment" as many lesser men would have done, he has written a number of new books. His "Pharmacology in Clinical Practice" appeared in 1952, and his "Drugs, Their Nature, Action and Use" in 1958. Only this year he published the interesting "Dilemmas in Drug Therapy." Every year since 1949 he edited the "Yearbook of Drug Therapy." Each of his contributions has been informative, stimulating, and helpful. He has left an indelible mark on American and world medicine. He has not finished yet. We are all very much in his debt for all he has done and is still trying to do.

Council *Award*

STATE MEDICAL SOCIETY OF WISCONSIN

Annual Meeting • Milwaukee • May 6, 1959

Presentation made by J. C. Fox, M.D.
Chairman of the Council

The highest honor in the power of the State Medical Society of Wisconsin to bestow upon one of its members is the Council Award. It is granted only upon occasion. It is granted only by unanimous vote of the Council. It is granted only to such as have served with outstanding distinction the science of medicine, their fellow physicians, and the public. In the 30 years since it was established, only 26 awards have been made.

Of those who have been its recipients, it may truly be said that they have personified the highest traditions of medicine in their devotion to the public good. Tonight, by direction of my fellow Councilors, we give another Council Award.

Harry Beckman, M.D.

A son of Kentucky, an adopted son of Wisconsin; a distinguished physician and pharmacologist; a graduate of the University of Louisville; an educator on the campus of Marquette University for over three decades, Professor and Director of Pharmacology in the School of Medicine; a brilliant teacher identified with scientific training programs throughout the world;

An inspiring friend in the hearts of a multitude of physicians who are practicing his philosophy in the art of medicine; an outstanding author who has also co-authored "Comments on Treatment" regularly in the Wisconsin Medical Journal; an active leader in the affairs of his Milwaukee County Medical Society; a learned lecturer in the teaching programs of the State Medical Society;

A celebrated scientist who has advanced the boundaries of medicine; a member of the Central Society of Clinical Research, Society for Experimental Biology and Medicine, American Society for Pharmacology and Experimental Therapeutics, Federation of American Societies for Experimental Biology, American Chemical Society, American Medical Association, American Therapeutic Society, American Association for the Advancement of Science;

Doctor Beckman, for your unfailing loyalty and devotion to the practice of medicine, for the rare combination of humility, skepticism and questing mind which has made you one of America's great medical scholars, for your admirable ability to transfer your own knowledge and idealism to young men and women entering the noble profession of medicine; for your eternal contributions to medical science as inquirer, author, tutor and advisor,

We, your fellow members, give you this seal of our Society as a token of your achievement and of our esteem and affection.

(Reproduced from original plaque)

Council *Award*

STATE MEDICAL SOCIETY OF WISCONSIN

Annual Meeting • Milwaukee • October 3, 1950

Presentation Made by R. G. Arveson, M.D.
Chairman of the Council

"It has been aptly observed that the success achieved by any organization is dependent upon the caliber of its membership and those within it who unsparingly give of their time, their energy, and their convenience in the interest of all. The State Medical Society of Wisconsin possesses a proud record in its service and in the service of its members to the public welfare.

"Its success has been achieved not as the result of the work of one man nor the efforts of a few. The Society numbers a host of contributors to its activities; yet among us in the profession there are some who have been given, as a result of their own devotion and by willing consent of others, greater opportunities of service than are enjoyed by all. Thus from among our membership there emerges from time to time one to whom we, as fellow practitioners of medicine, desire to pay humble tribute and to whom we extend the sincere appreciation of the medical fraternity for his exemplification of faithful and effective service to his profession and to the people served by it.

"Tonight I am privileged to bestow upon one of our members the highest honor of the State Medical Society of Wisconsin. It is the Council Award. It is granted only upon occasion. It is granted only by unanimous vote of the Council. It is granted only to such as have served with outstanding distinction the science of medicine, their fellow physicians, and the public. Since 1930, when the first Council awards were granted to two distinguished members of our profession, but twenty awards have been made. Tonight, by direction of my fellow Councilors, we give another:

"Doctor Armand James Quick, of Milwaukee, will you please rise?

"Armand James Quick, distinguished son of Wisconsin, held in the pride and esteem of your alma maters, Wisconsin, Illinois, and Cornell; early in your career a teacher and since 1935 a member of the faculty of Marquette University School of Medicine; now professor and director of the department of biochemistry in that institution; with Doctor M. H. Seevers of Madison, first co-editor of a section of The Wisconsin Medical Journal entitled "Comments on Treatment," a valuable and timely page of scientific medicine; author of note and a valued contributor to many scientific journals; preeminent in the subject of blood coagulation and hemorrhagic diseases, and recipient in 1944 of the Gold Medal of the Scientific Assembly of the American Medical Association for your exhibit 'Determination of Prothrombin'; an active participant in many national and professional organizations, including the American Chemical Society, Society for Experimental Biology and Medicine, Central Society for Clinical Research, American Society for Pharmacology and Experimental Therapeutics, American Society for the Advancement of Science, American Society of Biological Chemists, as well as your county, state, and national medical associations.

"For your attainments in the science and in the art of medicine and surgery; for your ability in research and as a teacher; for your championship of the necessity of adequate research to improve and promote the health of the people; for your many services to humanity and, in particular note, to the health and well-being of the children confined to the Milwaukee Children's Hospital; for your manifold contributions to the scientific knowledge of the medical profession; for your wise and patient counseling of your fellow practitioners and for your high and generous interest in the development of your professional organizations:

"We, your fellow members, give you this seal of our Society as a token of your achievement and of our esteem and affection."

(Reproduced from original plaque)

COLLECTED PAPERS . . . HARRY BECKMAN, M.D.

1924

1. On the alleged synergism of magnesium sulphate and morphine, J. Lab. & Clin. Med. 10:189

1925

2. The alleged synergism of magnesium sulphate and morphine, J.A.M.A. 85:332
3. Colonic anesthesia in dogs, Am. Vet. M.A. 67:No. 4

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4. Critique of the lipase "picture" methods, J. Lab. & Clin. Med. 13: 234
5. Nitrohydrochloric acid in the treatment of hay fever, Am. J. M. Sc. 174:525

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6. Nitrohydrochloric acid in the treatment of hay fever, Wisconsin M. J. 27:259
7. The alleged synergism of magnesium sulphate and morphine (a further communication), Am. J. Obst. & Gynec. 15:72

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8. Magnesium sulphate in "synergistic" analgesia and in tetanus, Am. J. Obst. & Gynec. 17:735
9. The alleged synergism of magnesium sulphate and morphine (present status of the controversy), J. Lab. & Clin. Med. 14: 1050
10. The acid treatment of hay fever, Med. J. & Record 130:9

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11. Allergy considered as a special type of alkalosis, J. Allergy 1: 496
12. Allergy and acidbase balance, J.A.M.A. 95:1582
13. Treatment in General Practice. Philadelphia, W. B. Saunders Co.

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14. Kalevala, the account of a very early people, Medical Life, Oct.

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15. A note on the acid treatment of hay fever, Wisconsin M. J. 31: 533

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16. The present status of bismarsen in the treatment of syphilis, New England J. Med. 208:487
17. Review of toxin–antotoxin and toxoid in diptheria immunization, Arch. Pediat. 50:211
18. Bismuth in the treatment of syphilis, J. Lab. & Clin. Med. 18: 1136
19. Fever therapy in neurosyphilis, Arch. Derm. & Syph. 28:309
20. Treatment of hay fever by desensitisation with acid, Lancet 1: 1227

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21. Treatment in General Practice. 2nd Ed. Philadelphia, W. B. Saunders Co.
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23. Treatment in General Practice. 3rd Ed. Philadelphia, W. B. Saunders Co.
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26. An economical method of obtaining blood from the canary, Proc. Soc. Exper. Biol. & Med. 43:268
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28. Failure to infect the great horned owl with sporozoites of plasmodium cathemerium, Proc. Soc. Exper. Biol. & Med. 45:477

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29. Experimentally derived method for determining the degree of infection in avian malaria, Am. J. Trop. Med. 21:151
30. Attempted immunization of canaries against plasmodium cathemerium by injection with filtered whole mosquito substance, Proc. Soc. Pharm. & Exper. Therap. p. 3, Apr. 15
31. Atabrine retardation of schizogomy in plasmodium cathemerium infected canaries, Am. J. Trop. Med. 21:795

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32. Course of infections with 3H2 strains of plasmodium cathemerium in canaries, Proc. Soc. Exper. Biol. & Med. 50:90
33. Treatment in General Practice. 4th ed. Philadelphia, W. B. Saunders Co.

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35. Ota, R. K. and *Beckman, Harry:* A large feeder for small cages in avian malaria studies, Science 97:124
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37. *Beckman, Harry and Smith,* Jane: A new method of counting plasmodium in avian malaria studies, J. Lab. & Clin. Med. 28: 1735

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THE WISCONSIN REGIONAL MEDICAL PROGRAM, INC.

MILWAUKEE, WISCONSIN

Dear Harry and Armand:

It is a rare privilege for a former student and colleague to congratulate both of you in one letter. Our careers in medical education have been closely intertwined during the last thirty-five years; and as I look back I now realize how much I owe both of you for the help and encouragement you gave in directing the affairs of Marquette University School of Medicine. It also has been a pleasure to bask vicariously in the well-deserved recognition which you have received from your colleagues and admirers all over the world.

Although each of you has contributed to medicine in a different way, and your scientific interests are dissimilar, you share a great accomplishment in common. Your dedication to the education of medical students, and the effort you have put into a lifetime of service for them, calls for the highest tribute from the physicians of Wisconsin. I am happy to join with them in honoring you.

Sincerely yours,

JOHN S. HIRSCHBOECK, M.D.
Regional Program Coordinator

39. *Beckman*, Harry and Smith, Jane: Correspondence re above paper, J. Lab. & Clin. Med. 29: 783
40. Continuous aquinine administration in avian malaria infections, Proc. Fed. Am. Soc. Exper. Biol. 3:66
41. Will returned-soldier malaria menace Wisconsin? Wisconsin M. J. 43:1222

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43. Blood transfusion in the postwar period, Interne 12:463

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44. Attempted infection of the hen and man with the sporosoites of plasmodium cathemerium 3H2, Proc. Soc. Exper. Biol. & Med. 66:401

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45. Treatment in General Practice. 6th Ed. Philadelphia, W. B. Saunders Co.
46. Infectivity of sporosoites of plasmodium cathemerium 3H2 exposed in vitro to hen and canary blood, Proc. Soc. Exper. Biol. & Med. 67:172
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55. Not in the think itself. Centennial Edition. Kentucky State Medical Ass'n
56. Chen, J. Y. P. and *Beckman, Harry:* Antispasmodic effects and toxicity of N-ethyl-e-piperidyl-diphenylacetate hydrochloride with special reference to its actions on the sphincter of oddi in the dog, J. Pharm. & Exper. Therap. 104:269
57. Pharmacology in Clinical Practice. Philadelphia, W. B. Saunders Co.
58. The 1952 Yearbook of Drug Therapy (August 1951–August 1952). Chicago, Year Book Publ.

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59. Evolution of a concept of cancer, Marquette M. Rev. 18:165
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64. Reid, Wm. and *Beckman, Harry:* Lymph deprivation and the antianaphylactoid action of salicylate, Marquette M. Rev. 20:116
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WE ACKNOWLEDGE with deep appreciation the assistance given by Miss Mary Dougherty of the Milwaukee Academy of Medicine in furnishing us with the bibliographies, biographical material, and pictures.—EDITORS

MARQUETTE UNIVERSITY

MILWAUKEE, WISCONSIN

Dear Drs. Beckman and Quick:

It is a distinct privilege for me, on behalf of your many friends at Marquette, as well as the hundreds of students who have benefited from your scholarship and teaching, to pay tribute to you at this time.

You are great men: great scientists, great educators, great humanitarians. Yet, no scientific procedure will ever be able to assess adequately the good that has come to mankind as a result of your magnificent careers, or even from your activities during retirement. Your combined total of nearly seventy years of service is truly remarkable! All of us at Marquette are supremely proud of your long and devoted affiliation with us, as we are immensely grateful for all you have done for Marquette and for others.

A basic aim of Marquette is to provide in its students vital qualities of leadership, and a growth and development which will enable them to bring the citizens of our city, state and nation to share fully in the rich resources we possess, and to help them to benefit from the acquisition and dissemination of truth and knowledge. For examples most worthy of their emulation, our students need only review the characteristics of your careers, and the staunch ideals and unselfish devotion of both of you—qualities which, in you, are living examples of the best for which they might hope.

Proudly, we offer our best wishes to you at this time, and with them, our deep gratitude and our prayers that God will give you many more wonderful fruitful years.

Sincerely yours,

JOHN P. RAYNOR, S. J.
President

THE STATE OF WISCONSIN EXECUTIVE OFFICE

MADISON, WISCONSIN

Dear Doctors Beckman and Quick:

Allow me to join with your colleagues throughout the State and Nation in paying tribute to your outstanding contributions to the medical profession during your many years of devoted service.

The fields of pharmacology and biochemistry, in which you are internationally known, have benefited a great deal from the tireless work and boundless energy that you men have exhibited.

Congratulations on the role that you have both played. All of the people of Wisconsin are grateful for your work and dedication to the cause of medical progress.

Sincerely,

WARREN P. KNOWLES
Governor

THE MEDICAL SOCIETY OF MILWAUKEE COUNTY

MILWAUKEE, WISCONSIN

Dear Friends:

Few men of science, particularly in the field of medicine, are fortunate enough to receive the accolades of their colleagues during their lifetime.

To you, Doctors Harry Beckman and Armand Quick, such honors are extended by all of the members of The Medical Society of Milwaukee County. You are known personally to most and by reputation by all of us.

Your dedication to medical research and its application to improved patient care, your patience as teachers, your concern for the sick, and your continued interest in pharmacology and biochemistry during these retiring years. All of this make you, Dr. Harry Beckman, and Dr. Armand Quick, great men of modern medicine.

By your works you have also brought honor and distinction to the medical profession, your alma maters, and to The Marquette University School of Medicine.

It is a privilege to join in this tribute to you.

Sincerely,

CHRISTOPHER ROBERT DIX, M.D.
President

1956

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67. Differential distribution of enzyme hydrolyzing acetylsalicylic acid (aspirin) in certain fluids of the rat, Proc. Soc. Exper. Biol. & Med. 93:144
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84. The nature of plasmodium gallinaceum hosp specificity: Apparent site of sporozoite arrest in the non-susceptible species, Am. J. Trop. Med. & Hyg. 12:519

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86. Search for clinical evidence of an exoerythrocytic state in mice exposed to plasmodium gallinaceum infection, Proc. Soc. Exper. Biol. & Med. 115:559

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COMMENTS ON TREATMENT

Wisconsin Medical Journal

1946

1. Blood transfusion malaria in the post-war period, 45:217, February
2. Improving penicillin activity, 45:322, March
3. Benzl penicillin, 45:407, April
4. Folic acid in the anemias, 45:501, May
5. Iron, 45:601, June

1947

6. The field of streptomyin usefulness, 46:233, February
7. Prophthiouracil, 46:325, March
8. Oral and aerosol penicillin in infants, 46:423, April
9. A few of the older anti-asthmatics, 46:524, May
10. Penicillin resistance, 46:621, June

1948

11. Penicillin reactions, 1948, 47:214, February
12. Therapy of infectious hepatitis, 47:306, March
13. Therapy of pulmonary embolism, 47:399, April
14. Choice of a digitalis preparation, 47:483, May
15. Oral administration of a mercurial diuretic, 47:602, June

1949

16. Vitamin B_{12}, 1949, 48:159, February
17. Toward wider spacing of penicillin doses, 48:251, March
18. Caronamide, 48:342, April
19. The neglect of papaverine, 48:430, May
20. Atropine and physotigmine substitues, 48:517, June

1950

21. Newer drugs in the treatment of herpes zoster, 49:142, February
22. Atabrine and parenteral quinidine in treatment of arrhythmias, 49:220, March
23. Phisoderm and hexachlorophene for disinfection of the skin, 49:305, April
24. Intravenous administration of procaine in children, 49:394, May
25. Early handling of apoplexy with aminophylline, 49:512, June

1951

26. Clinical usefulness of ACTH and cortisone, 50:183, February
27. Good old aspirin!: 50:281, March
28. Veratrum viride in hypertension, 50:380, April
29. Digitalis and oxygen for cor pulmonale, 50:470, May
30. "Clinical" versus "chemical" use of insulin, 50:591, June

1952

31. Urinary antiseptics, 1952, 51:185, February
32. Papaverine suppositories in myocardial infarction, 51:275, March
33. Dangers of intrathecal medicine, 51:384, April
34. Hydrasides of isonicotinic acid in tuberculosis, 51:493, May
35. Plasma substitutes, 51:600, June

1953

36. Some 1952 developments in the drug therapy of infectious diseases, 52:157, February
37. Some other 1952 developments in drug therapy, 52:208, March
38. Questions and answers suggested by recent investigations in drug therapy, 52:247, April
39. Ibid, 52.290, May
40. Ibid, 52:334, June

1954

41. Questions and answers suggested by recent investigations in drug therapy, 53:177, February
42. Ibid, 53.219, March
43. Ibid, 53.257, April
44. Ibid, 53:311, May
45. Ibid, 53:356, June

NORTH AMERICAN AVIATION, INC.

DOWNEY, CALIFORNIA

Dear Doctor Beckman:

This occasion is most befitting to share with the many thousands of your students and colleagues, the unanimous expression of respect for your outstanding achievement in teaching and in publications used by us as an authoritative guide or standard reference in drug therapy. Of international renown, but of special personal value to me, has been your "Treatment in General Practice" (this was used as our standard therapeutic textbook when I was a medical student at Peiping Union Medical College in China during 1937–41), as well as "Pharmacology in Clinical Practice," "Drugs—Their Nature, Action, and Use," the recently published "Dilemmas in Drug Therapy," and the "Year Book of Drug Therapy" published annually.

Your lucid presentation of complex scientific medical data and your practical approach to clinical use of drugs have undoubtedly established precedence in pharmacological writing.

During our ten-year association at Marquette University School of Medicine, I had often witnessed your long hours of steadfast devotion towards building and achieving high academic standards. The milestones you have established will long remain major guideposts to those you have inspired.

May I join the many distinctive attestations of esteem you are receiving on this occasion in expressing my personal affectionate regard and in paying tribute to your distinguished career and accomplishments—professor, author, clinical pharmacologist, investigator, and consultant—in the field of pharmacology and drug therapy.

Sincerely,

JAMES Y. P. CHEN, M.D.
Head, Pharmacology
and Experimental Medicine

THE UNIVERSITY OF WISCONSIN MEDICAL CENTER

MADISON, WISCONSIN

Dear Dr. Beckman:

I am most grateful that I have been asked to address you at this time when a special edition of the State Medical Journal is to be published as a tribute to you and to Dr. Quick. Such a richly deserved honor is so proper, and I am pleased by the thoughtfulness and justice of the occasion.

Your distinction as an outstanding scholar, brilliant teacher, author of eminence, and scientist have been appreciated by thousands of physicians and students throughout the world. You have brought great honor to your alma mater, the University of Louisville and to Marquette where you have so long and so superbly served as Professor of Pharmacology. Your past and continuing productivity has had a great impact upon us all, and that you carry on so actively is truly impressive.

It has been a pleasure to have known you—for too short a time, I am sorry to say. My most sincere congratulations and best wishes.

Sincerely yours,

PETER L. EICHMAN, M.D.
Dean

AMERICAN SOCIETY FOR PHARMACOLOGY AND EXPERIMENTAL THERAPEUTICS

VANDERBILT UNIVERSITY
NASHVILLE, TENNESSEE

Dear Harry:

On this occasion I wish to add the congratulations of not only myself but other members of our Society. Your devotion to and interest in the activities of the Pharmacology Society have, of course, been outstanding. You will be particularly remembered in the Society for the successful effort you made in behalf of the training grant program.

Your many other activities in behalf of medical education are also greatly appreciated. As a member of the pharmacology community, I have particularly appreciated your infectious enthusiasm for the future of our discipline and your untiring efforts directed toward emphasizing the important role which pharmacology plays in medicine today.

With warmest personal regards,

Sincerely yours,

ALLAN D. BASS, M.D.
President

1955

46. Questions and answers suggested by recent investigations in drug therapy, 54:167, February
47. Ibid, 54:192, March
48. Ibid, 54:212, April
49. Ibid, 54:258, May
50. Ibid, 54:310, June

1956

51. Digitalis in the shock of coronary occlusion, 55:174, February
52. The placebo, 55:277, March
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HARRY BECKMAN, M.D.

Born: August 14, 1892, Louisville, Kentucky

1921: M.D., University of Louisville

1921–1923: Internship, New York City

1923: Instructor, Department of Physiology and Pharmacology, Marquette University School of Medicine, Milwaukee

1923–1925: Assistant Professor, Ibid

1925–1926: Associate Professor and Acting Director, Department of Pharmacology, Marquette University School of Medicine, Milwaukee

1926–1961: Professor and Director, Ibid

1962: Professor Emeritus, Ibid

1966: Houghton Fellow in Clinical Research, Columbia Hospital, Milwaukee

1930–1931: University of Vienna, Advanced Study

Consultant, Milwaukee County General Hospital and Columbia Hospital

Past President, Milwaukee Academy of Medicine, 1949

Past President, American Society for Pharmacology and Experimental Therapeutics, 1956

Council Award, State Medical Society of Wisconsin, 1959

Teaching Award, Marquette University School of Medicine, 1960

Distinguished Service Award, Marquette University School of Medicine, 1961

DOCTOR QUICK'S bibliography and other recognitions will appear in the August issue.

WISCONSIN STATE BOARD OF HEALTH

MADISON, WISCONSIN

Dear Doctors Beckman and Quick:

As Secretary of the State Board of Health I would like to extend to you the congratulations of this body for your dedicated services in behalf of the hundreds of physicians and innumerable patients who have benefited from your fine work.

There is no field of endeavor more important to medicine than the unbiased and scientific evaluation and research on the safety and value of drugs. As in public health the benefits of your labor extend far beyond the circle of your own patients.

Your contributions to the improvement in medical care are well recognized by your fellow physicians throughout the world.

Congratulations for a job well done.

Sincerely yours,

E. H. Jorris M.D.

E. H. JORRIS, M.D.
State Health Officer

THE UNIVERSITY OF WISCONSIN MEDICAL CENTER

MADISON, WISCONSIN

Dear Dr. Quick:

It is with great pleasure indeed that I address my thoughts to you, and I am honored by being selected as a participant in this Festschrift which is so richly deserved.

You have added lustre to your three alma maters, which includes Wisconsin, to Marquette where you have so long been a distinguished faculty member of great scholarship, productivity, and eminence. Your outstanding international reputation as a scientist has brought high honor to our great state of Wisconsin and to our nation.

It has been my pleasure to know you—for too short a period, I am sorry to say—but I am inspired by your numerous past and continuing accomplishments. That you are still very active and productive provides stimulation for us all.

I extend to you my most sincere congratulations and best wishes.

Sincerely yours,

Peter L. Eichman

PETER L. EICHMAN, M.D.
Dean

Tribute to a Retiring Editor

By HAROLD F. HARDMAN, M.D., Ph.D., Milwaukee, Wisconsin

WE NEED HIS example more than he needs our good wishes for the coming years. This is my personal feeling for Harry Beckman who has contributed so much to the development of Wisconsin physicians and the sciences of medicine and pharmacology. Over three thousand physicians have been exposed to the colorful personality and erudite teaching of Harry Beckman in the lecture halls of Marquette University School of Medicine. First and foremost he has been a teacher par excellence. Constantly varying the technique of presenting information about the rational use of drugs to medical students in the classroom he has also taught physicians throughout the world with his extensive writings in the form of papers, textbooks, Year Books of Drug Therapy and our own state medical journal. His refreshing and crisp personal style of writing can only be compared with the outstanding medical teachers of the century.

THIS "Tribute to a Retiring Editor" was published in the March 1962 issue of the Journal *upon the retirement of Doctor Beckman from the co-editorship of the "Comments on Treatment" pages following his retirement as director of Marquette University's Department of Pharmacology. As noted elsewhere in this issue, Doctor Beckman has never really retired from writing and actually is turning most of his attention now to just that. With the new series of "Therapeutic Dilemmas" starting in this issue, Doctor Beckman again is contributing to the* Journal *excellent material which Wisconsin physicians and numerous others around the country will be looking forward to reading.*

—THE EDITORS

Harry Beckman was born in Louisville, Kentucky. His early exposure to formal academic training was not to his liking and he left the classroom to explore the open spaces as a county agricultural agent. It was this early experience as teacher, naturalist and traveler that subsequently led him into the field of medical education. In his peripatetic functions as a county agent he developed a true love for books and scholarship which is undiminished in intensity after more than fifty years of daily practice. This led to his very first scientific publication entitled, "What can we do with our manure?" This paper has caused him to receive much good natured ribbing but characteristically he replies that "a man must start somewhere and pull on his own boot straps." From this beginning has evolved a professional career of scientific writing and editing unequaled by any living pharmacologist.

About 1917 he entered a formal program in medicine at the University of Louisville and received his M.D. degree in 1921. This was followed by a two year internship at the New York Skin and Cancer Hospital. A brief career as a ship's doctor followed and then he began his long association with Marquette University as an instructor in physiology and pharmacology in 1923. He rose rapidly through the ranks and was appointed professor and chairman of the department of pharmacology in 1926. On January 1, 1962 he retired from the administrative duties of departmental chairman to devote his full efforts to research in the field of malaria and to continue editing his Year Book of Drug Therapy. As a professor of pharmacology he will continue his association with Marquette University where his colleagues will draw upon his vast experience and knowledge for help in their problems.

His perception of the important areas for improvement in the field of pharmacology and his personal effort to solve these problems led to the introduction of Training Grants from the Public Health Service for departments of pharmacology in the United States. Without this important legislation we could not hope to provide adequate numbers of teachers in pharmacology for the task of training increasing numbers of physicians for our rapidly expanding population.

There are too many examples of his wise leadership to enumerate here which reflect his character, integrity and personal generosity that his associates value so dearly. We need his example of dedication to one's work to appreciate his personal philosophy that the joy of doing a job well is reward in itself. We at Marquette University feel especially honored to have Harry Beckman as our continuing associate.

THE PRESIDENT'S PAGE

HAROLD J. KIEF, M.D.

SMS means aggressive leadership

Bettercare—Not Medicare

■ WE HAVE STATED before and we will continue to state the fact that through legislation, particularly Titles 18 and 19 of the Social Security Amendments of 1965, this nation has asserted that each individual has the right to adequate medical care. Furthermore, our nation has begun to provide, through many federal, state, and private mechanisms, payment systems by which this right may be secured.

As physicians and as members of a service profession, we have the obligation to deliver this "bettercare." As individuals or as organized groups, we can help only in a small way to reduce manpower shortage—the shortages of physicians, of nurses and of all other medical and paramedical personnel. But we can this year, yes, even this summer, begin to correct the deficiencies in the delivery of medical services.

Every county medical society should, through its executive committee, begin to explore and survey its county and community with the thought in mind of delivering bettercare to its own area. Not only will this be our job but also our duty, a duty we owe to our profession but, even more importantly, a duty we owe to our patients.

The director of the National Institutes of Health, Dr. James A. Shannon, in a speech delivered in Washington, D. C. on Jan. 16, 1967, said: "It is the national purpose to correct deficiencies in the delivery of medical services by using the present system of medicine as the core structure for social embellishment rather than by attempting to build a new system." You and I may not accept these words of Doctor Shannon and we may disagree with them, but we must believe that this is the challenge presented to medicine today—the delivery of "bettercare."

Where are we negligent in the delivery of medical services? Is it in the poor emergency room service? If so, it is the duty of county medical societies to improve this emergency service, whether it be in the area of transportation, staffing the emergency room, or the physical facilities themselves.

Perhaps we can enhance the delivery of better medical services by enlarging outpatient facilities: not the physical plants, but our services. Are our medical services available at all times to our communities? Do we, as practicing physicians, or do the communities have available at all times a member of our specialty groups? Is a surgeon always present or available? Is an ophthalmologist present and on duty at all times? An orthopod? Could members of a county medical society—all members working in harmony—activate a rotation system? A system such as this could be posted in the emergency room of the local hospitals so that all physicians would know who is on call. Discreet news articles will inform the public that you, the local medical organization, have available better medical services.

Can the medical services to our communities be improved by attracting more of the specialty groups into our areas? In order to do this, do we need better facilities? Should the community help us, the medical profession, in providing better facilities so that we can attract more physicians in our area, physicians who can give the specialized, superior care needed by certain segments of our ill population?

These are but a few of the problems which I'm sure have been confronting all the medical communities around the State of Wisconsin. Where can we go for help? Is there another area that we, as physicians, have not learned about sufficiently or are there others who may be able to help us in the delivery of bettercare?

I think it is of paramount importance that all physicians in the State of Wisconsin be very well acquainted with The Wisconsin Regional Medical Program, the program which has as its director Dr. John Hirschboeck.

The Wisconsin Regional Medical Program, as all others in the United States, was formed after enactment of Public Law 89–239, the Heart-Cancer-Stroke Amendment of 1965 to the Public Health Service Act. Our legislatures allotted three years for planning. In 1968, these regional medical programs will be operational. The intent of any of these programs is to deliver better patient care. The act itself states that regional medical programs would utilize and build upon existing institutions and manpower resources, and goes on to propose definitely that the active participation of practicing physicians is essential to the success of a regional medical program.

We, as physicians, can help ourselves and our patients in this program through initiative, planning, and implementation which encourages approaches specifically designed to deal with the needs, resources, and existing patterns of practice and education in any given area. Cooperation among all essential elements of the health resources in a region is an essential means of coping with the complexities, specialization, high cost, manpower needs, and education and training needs which we have found are the byproducts of the dynamic advances of medical science.

In essence, then, the purpose of The Wisconsin Regional Medical Program is to establish cooperative arrangements locally and between the major centers—medical schools, research institutions, hospitals, and clinics—for research training and education for the provision of better patient care.

It is fitting, therefore, that we survey our own community to see if what we are doing is adequate now and for the future; or, do we have problems in the provision of better medical care that we, as a profession, should admit and in some cooperative fashion attempt to solve?

I believe the answer is obvious. Petty jealousies, differences of opinion, differences in area. I believe, should be forgotten. It is in this year, 1967, that all medical communities should plan and use all the resources available to give bettercare. Then we will never have to fear medicare.

H J Kief MD

AMA HEAD VOICES SUPPORT OF NEW FAMILY MEDICINE SPECIALTY

The new president of the American Medical Association has called on all members of his organization to support the soon-to-be-launched specialty of family medicine. Dr. Milford O. Rouse, Dallas, Tex., included the charge in his address to the House of Delegates of the AMA at the annual session in Atlantic City, N. J., June 26–29.

"The American Board of Family Practice, soon to be launched, will need sympathetic understanding by all of us," Doctor Rouse, a practicing gastroenterologist, said. "We owe it to the new specialists, not only to give them our support during their years of education and resident training, but to help them find the best place to locate and help give them access to hospitals in the communities where they practice."

The plea to assist the new specialty followed a statement that "intelligent, broad-minded cooperation will be needed to implement the decision of the AMA to stimulate the training and work of more family physicians."

The new specialty, which will require three years of post-M.D. graduate training before a certification examination may be taken, will feature not only the usual clinical areas of study but preparation in the behavioral sciences and in preventive health care. It will become the 20th primary specialty in medicine.

the WISCONSIN MEDICAL JOURNAL
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EDITORIALS

D. N. GOLDSTEIN, M. D., *Editorial Director*

Practical Psychology

■ THE MILWAUKEE JOURNAL recently pointed its editorial finger at the consistently negative attitude of organized medicine first toward the establishment of medicare and now toward its expansion. The newspaper noted that medicare is here to stay and that it will probably be expanded despite the opposition of the American Medical Association. "It would be better," concluded the JOURNAL, "if expansion came with medicine's cooperation and support."

Contrary to the predictions of spokesmen for the AMA and the anticipation of many doctors, the establishment of medicare has not meant the end of free enterprise in the practice of medicine. It has not significantly interfered with the relationship between doctor and patient, and it apparently has eased the burden of health care costs for many elderly people. Social security costs have increased for the entire population and the volume of paper work imposed on doctors has risen precipitously but, on balance, medicare probably must be assessed as a positive value.

What medicare might have been without the consistent opposition of organized medicine is hard to say. Unquestionably the opposition served to limit excesses that might have been written into the bill; the moderate, nondisruptive character of the present program derives from the creative democratic process that produces something less than the proponents wanted to have and something more than the opponents wanted to permit.

Opposition is not useless when it is realistic and constructive. Unfortunately, the medical profession has a reputation in some quarters for blind, mindless opposition for the sake of opposition. As the MILWAUKEE JOURNAL suggests, organized medicine has an important role to play in the planning of future health care programs. The programs are going to come about anyway, and it would be better for the representatives of medicine to approach their problems positively. It is psychologically smarter to take a position of approval *with amendments* rather than simple opposition. To work to curb excesses, to limit extremes, to modify and control is not to compromise principle. It is, instead, to participate, and, by participating, to act in a responsible, socially valuable manner.—DNG

Smokers Option

DESPITE THE Surgeon General's report and despite the warning printed on each package of cigarettes, cigarette smoking has not been drastically reduced. This is not unusual, given the aggressive advertising programs of the cigarette manufacturers and their subtle motivational appeals.

The government has gone about as far as it can, or cares to, go in discouraging people from smoking. Public health agencies have publicized the danger, and the Congress has made sure that anyone who buys a package of cigarettes knows that he is exposing himself to a health hazard. But people continue to smoke cigarettes.

Some cigarette brands have recently listed the tar and nicotine content on the package, hopefully to attract those people who can't give up smoking but are concerned about the hazard. But most of the brands continue to appeal to the smoker on grounds of taste, coolness, mildness, and the like.

Roswell Park Memorial Institute recently completed a study that demonstrates a wide variation in the tar and nicotine content of 56 brands tested, regardless of taste, coolness, or mildness. Tar yields alone ranged from 8 mg per cigarette to 43 mg, with significant differences in different types of the same cigarette. Longer cigarettes, even with filters, the study shows, expose the smoker to much more tar and nicotine.

The conclusion can't be escaped that the cigarette manufacturer bears an undeniable responsibility to make a product with as little of the suspected carcinogens as possible. If they are going to induce people to start to smoke and to continue to smoke, the moral burden rests with them to produce a cigarette that minimizes the risk. If one manufacturer can market a cigarette having a low yield of particulates, it is incumbent on all the others to do likewise.—DNG

Sparta's Doctor Spencer Beebe, Well-Known Country Doctor

A TOWERING figure in Wisconsin medicine has left us. Dr. Spencer Beebe, 97, Sparta, one of the state's best-known physicians, died Sunday (June 25, 1967) in the County Clinic after a long illness.

For many years Dr. Beebe was the state's oldest active general practitioner and he served as the Monroe County Clinic's physician well into his 90's. Until infirmities brought on by his advanced age made him give up his patient care, Dr. Beebe attended the needs of some 400 persons in the hospital.

Thousands of Wisconsin citizens were ushered into the world by the man who was named "Wisconsin's Country Doctor of the Year" in 1950. He was also the recipient of the State Medical Society's highest award, the Council Award.

He was a staunch friend of *The Capital Times* and a regular contributor to this newspaper's Kiddie Camp fund.

A firm advocate of Prohibition, Dr. Beebe devoted major efforts in behalf of this cause.

"The greatness, yet the honest simplicity of this physician is felt throughout the state," Dr. Beebe was told at the Medical Society award ceremony.

It is a fitting tribute to his greatness. He was a warm friend to many and our condolences go out to members of his family.—*Reprinted with permission from* THE CAPITAL TIMES, June 26, 1967

Medicine in the United States: The Road from Yesterday to Today

AS ONE WOULD anticipate, radical changes have occurred in the transition from the horse and buggy medicine to the space era. The empiricism that still marked the 90s has given way to the scientific approach in the laboratory, clinic, and sickroom. The modern physician is capable of infinitely more exact practice than his grandfather. Therapeutic advances have vastly improved his care of patients. The surgical approaches to intracranial lesions, diseases of the lung, and disorders of the heart and vessels are essentially all developments of this period. Truly there are no secret hiding places that escape the modern surgeon. Specialization is basically a product of this period through the vast growth of medical knowledge. The manner of practice shows a steady movement toward the hospital. Although abundantly evident at this time, automation and mechanization will be increasingly utilized in medicine in the future. Let us consider: seventy-five years from now, some essayist will reflect on the backward state of the science and the art of medicine in 1966. Certainly, ever broader, brighter vistas are still ahead.—Excerpt from paper of William S. Middleton, M.D., Madison, in JOURNAL-LANCET, November 1966.

Minutes of Council Meeting

MILWAUKEE, MAY 7, 1967

1. Call to Order and Roll Call

The meeting was called to order by Chairman Fox at 2:00 p.m. on Sunday, May 7, 1967, at the Sheraton–Schroeder Hotel in Milwaukee.

Voting members present were Doctors James, Schulz, Nordby, Davis, Stoops, Carey, Blanchard, Sisk, Dettmann, Fox, Boren, Ludwig, Manz, Grand, Egan, Chojnacki, Hollenbeck, Van Hecke, J. H. Houghton, Drew, and Callan.

Officers and others: Doctors Kief, Behnke, Bell, Bernhart, Hildebrand, Collentine, Hill, Picard, Simenstad, Dessloch, Hilliard; Messrs. Crownhart, Koenig, Maroney, Salt, Reynolds, T. H. Murphy, Johnson, Waldschmidt, Brower, Jacobson, Gill, White, R. B. Murphy, Kluwin, Tiffany, W. J. Brown; Mrs. Anderson and Miss Pyre. Doctor Gundersen, Mr. Thayer, and members of the board of directors of the Professional Association for Civic Education were present for a special order.

2. Approval of Minutes

On motion of Doctors Blanchard–Schulz, carried, minutes of the Council meeting of March 11–12, 1967, were approved.

3. Commission on State Departments

By motion duly made, seconded and carried, the following were elected to the Commission on State Departments for the ensuinig year:

T. W. Tormey, Jr., M.D., Madison, *General Chairman*

W. J. Egan, M.D., Milwaukee, *Vice-chairman*

Division chairmen

Chest Diseases: H. A. Anderson, M.D., Stevens Point

Ear, Nose, and Throat: Meyer S. Fox, M.D., Milwaukee

Handicapped Children: John J. Suits, M.D., Marshfield

Maternal and Child Welfare: J. R. Evrard, M.D., Milwaukee

Nervous and Mental Diseases: A. A. Lorenz, M.D., Eau Claire

Rehabilitation: P. A. Dudenhoefer, M.D., Elm Grove

Safe Transportation: J. L. Weygandt, M.D., Sheboygan Falls

School Health: J. C. H. Russell, M.D., Fort Atkinson

Vision: James V. Bolger, M.D., Waukesha

Aging: George G. Stebbins, M.D., Madison (elected at March meeting)

4. Report of Treasurer

J. B. White, C.P.A., discussed the annual report of the treasurer in behalf of Doctor Weston who was unable to be present. It was accepted by the Council.

5. Late Resolution for Introduction Through the Council

Doctor Chojnacki presented a resolution in behalf of The Medical Society of Milwaukee County to commend Congressman Zablocki for introduction of a bill to amend Title XVIII of the Social Security Act to permit an individual to be paid for charges by a physician under the supplementary benefits program prior to the individual's own payment for the charges involved.

On motion of Doctors Van Hecke–Chojnacki, carried, the resolution was forwarded to the House of Delegates.

6. Cardiac Intensive Care Units

Following discussion, the matter of the privilege and responsibility of nurses assigned to cardiac intensive care units was referred to the Executive Committee for study and report.

7. Professional Association for Civic Education

Doctor Gundersen reported to the Council on the educational activities engaged in since organization of this association last year.

8. Beaumont Commemorative Stamp

On motion of Doctors Blanchard–Ludwig, carried, the Council approved and forwarded to the House of Delegates with its endorsement a resolution to seek issuance of a commemorative stamp honoring Doctor Beaumont in 1972.

9. Report of Committee on Economic Medicine

(a) Group Pension Plan for Society Members

Doctor Blanchard reported that the committee had reviewed a proposal by Prudential Insurance Company of America to provide a group pension program under which participants might allocate contributions to a fixed or variable annuity fund. The committee recommended that the proposal receive further consideration by the Council.

(b) Group Life Insurance Program

The commmittee reviewed a written proposal by Time Insurance Company on a term life insurance program with all members paying the same premium and the amount of benefit decreasing according to the age of participants. This was intended to supplement the existing group program with Bankers Life.

The committee reported its intention to consider the matter further at an ensuing meeting with a representative of the company.

(c) Professional Liability—New Jersey Plan

The committee recommended that the New Jersey Supreme Court procedure in professional liability claims be further explored by the Council with advice of legal counsel on possible implementation in Wisconsin.

Mr. Kluwin explained that he had been unable to attend the committee meeting and asked that it be held in the committee for further study and report to the Council with recommendations.

(d) Resolution F, May 1966 Annual Meeting

The committee reported that this resolution, requesting that the group disability insurance plan provide coverage for "all members, whether or not they be in a full dues paying membership classification and actively engaged in medical practice," had again been considered in light of dissatisfaction of Milwaukee County with earlier action to the effect that the resolution could not be implemented without serious jeopardy to the entire program.

It concluded that there was a need for clarification of the associate membership status and its being granted only in accordance with Chapter VIII, Section 4 of the Bylaws. The committee rec-

ommended further that each such membership should be subject to annual evaluation.

(e) Annual Report on Insurance Plans for Society Members

The committee reported its review with the Society's insurance consultant of the disability, life, and business overhead plans.

On motion of Doctors Egan–Nordby, carried, the report of the Committee on Economic Medicine was adopted.

10. Report of Executive Committee

(a) Advisors to Wisconsin State Medical Assistants Society

On motion of Doctors Van Hecke–Hollenbeck, carried, the Council approved nominees of Doctor Kief to serve as advisors for the ensuing year: Drs. R. M. Baldwin, Beloit; C. E. Oberdorfer, Racine; and M. D. Davis, Milton.

(b) State Board of Medical Examiners

With four terms expiring in July on this state board, the Executive Committee proposed a slate of nominees for consideration of the Governor in making appointments. On motion of Doctors Blanchard–Chojnacki, carried, the slate was approved with two additions.

(c) Special Report on Osteopathy

The Secretary discussed this report which was forwarded to the Council with the recommendation of the Executive Committee.

On motion of Doctors Nordby–Houghton, carried, the Council accepted the report and forwarded it to the House of Delegates as presented. Doctor Drew asked to be recorded as voting "no."

(d) Personal Service Corporations

Pursuant to Council action in 1962, the Executive Committee reported its authorization of Society counsel to enter a particular case involving a Wisconsin corporation as amicus curiae.

(e) WISCONSIN MEDICAL JOURNAL Policy

The committee reported approval of increased subscription rates and a broader application of rates for classified ads. It recommended Council approval of accepting advertisements of securities provided written assurance is received that the advertisement has been cleared with the Securities and Exchange Commission and the appropriate state Securities Commissioners, or is otherwise exempt.

On motion of Doctors Chojnacki–Blanchard, carried, the recommendation was approved.

(f) Commission on Public Relations and Communications

The Council accepted the appointment of W. E. Myers, M.D., of Fond du Lac, and G. W. Dean, M.D., Milwaukee, to vacancies which occurred on this commission during the past year.

(g) School Health Resolutions

On motion of Doctors Houghton–Ludwig, carried, the Council forwarded to the House of Delegates a series of resolutions on health education in schools.

On motion of Doctors Blanchard–Grand, carried, the entire report of the Executive Committee was approved.

11. Report of the Secretary

Mr. Crownhart discussed some of the problems facing the medical profession in the future as he saw them, and suggested for consideration that Wisconsin carry a proposal to the American Medical Association board of trustees on creation of a joint commission with the legal profession and the clergy to study such matters as the law of privilged communications related to paramedical personnel; liability of limited licensees; the limits of the principle of implied consent; human experimentation with spare parts; abortion laws, etc.

The Secretary also requested that the Insurance Director be classified as an associate secretary, thus indicating his authority in the absence or disability of the Secretary, and creating a job classification such as extended others in the office as executive assistants, etc.

Doctors Nordby–Manz moved acceptance of the report. Discussion was held in executive session and this request was approved by ballot, the vote being 14 in favor with 6 to the contrary.

12. Report of AMA Delegation

(a) AMA Group Disability Insurance Program

The delegation recommended submission of the following resolution to the House of Delegates:

> "*Resolved*, That the State Medical Society of Wisconsin favors that all possible steps be taken to preserve the Disability Insurance Program of the AMA at the present level of benefits and premiums."

It was also suggested that a suitable article be prepared for the WISCONSIN MEDICAL JOURNAL explaining the "chain of command" within the AMA and also within the State Society since several physicians who communicated with the AMA delegates and alternates seemed to be of the opinion that the Wisconsin delegation had voted to alter the AMA insurance program.

(b) S. 260, 90th Congress (Hart Bill)

The delegation recommended submission to the House of Delegates of a resolution relating to this and similar legislation which, if adopted, would be introduced to the AMA House of Delegates.

(c) George B. Larson

The delegation recommended submission to the House of Delegates of a resolution commending this former employee of the State Society who soon will retire from the executive staff of the AMA, which also would be introduced to the AMA House of Delegates.

On motion of Doctors Nordby–Drew, carried, the report and recommendations were accepted.

13. Legislative Report

The Council agreed to forego an oral report by legislative counsel since a written supplementary report on legislation had been prepared for the House of Delegates.

14. Division on Nervous and Mental Diseases

The Council approved transmittal of the report of this Division to the House of Delegates.

15. Roy T. Ragatz

A resolution by the Commission on Scientific Medicine extending appreciation to Roy T. Ragatz for his years of service to the Society was presented to the Council.

On motion of Doctors Van Hecke–Hollenbeck, carried, the Council voted to join in the resolution and transmit it to the House of Delegates.

16. Adjournment

The meeting adjourned at 5:25 p.m.

C. H. CROWNHART
Secretary

Approved:
JAMES C. FOX, M.D.
Chairman

Minutes of Council Meeting

MILWAUKEE, MAY 10, 1967

1. Call to Order and Roll Call

The meeting was called to order by Chairman Fox at 11.:00 a.m. on Wednesday, May 10, 1967, at the Sheraton–Schroeder Hotel in Milwaukee.

Voting members present: Doctors Schulz, Nordby, Davis, Stoops, Carey, McRoberts, Sisk, Dettmann, Fox, Boren, Ludwig, Manz, Grand, Egan, Chojnacki, Hollenbeck, Sullivan, Van Hecke, Wright, President Kief and Speaker Behnke.

Others present were President-elect James, Vice-speaker Nereim; Doctors Bell, Bernhart, Hill, Picard, Simenstad, and Blanchard; Doctors Payne of Michigan, and Goodyear of Illinois; Messrs. Crownhart, Koenig, Brower, Maroney, Johnson, Waldschmidt, Jacobson, Lockerbie, Graham, Heinrichs, Kluwin, Murphy, White; Mrs. Anderson and Miss Pyre.

2. Introductions and Oath of Office

Newly elected councilors, officers, and guests were introduced, and the oath of office was administered by the chairman to Doctors McRoberts, Sullivan, Behnke, Nereim, and James. Doctor Bayley was not able to be present at the meeting held just after his election as councilor.

3. Organization of the State Medical Society of Wisconsin

Doctor Fox reviewed provisions of the Constitution and Bylaws and commmented on the duties and responsibility of councilors.

Mr. Crownhart presented slides and commentary on the organization of the Society, its divisions, and affiliated organizations, indicating the substantial number of member physicians who participate in their affairs.

4. Election of Officers

By separate motion duly made, seconded and carried, the following were elected to office for the ensuing year.

Chairman of the Council: JAMES C. FOX, M.D., La Crosse

Vice-chairman of the Council: E. J. NORDBY, M.D., Madison

Treasurer of the Society: F. L. WESTON, M.D., Madison

Assistant Treasurers: H. KENT TENNEY, M.D., Madison
N. A. HILL, M.D., Madison
J. T. SPRAGUE, M.D., Madison
R. A. SIEVERT, M.D., Madison

Editorial Director: D. N. GOLDSTEIN, M.D., Kenosha

5. Ad Hoc Committee Report

Doctor Nordby reported in behalf of the special committee authorized by the Council in March that it has met on three occasions and has been made aware of the facts of the situation in two hospitals of concern.

It was the unanimous opinion of the committee that the medical staffs of the respective institutions are progressing toward solution of the several problems to accomplish better medical care for their patients. The committee has offered its good offices should the parties seek advice.

On motion of Doctor Chojnacki–Schulz, carried, the report was accepted.

6. Ad Hoc Committee on Medical Practice Act

The Chairman announced appointment of this committee, also authorized at the March meeting: Drs. W. T. Russell, Sun Prairie, chairman; H. G. Bayley, Beaver Dam; Jack D. Brown, Sparta; B. J. Mansheim, La Crosse; and M. D. Davis, Milton.

7. Communications

Letters of appreciation were read from O. A. Mortensen, M.D., for his honorary membership, and from R. E. Fitzgerald, M.D., for his life membership.

The Council also was advised of the appointment by the president-elect of the American Bar Association of Robert B. Murphy as a member of a special committee to cooperate with the American Medical Association. Congratulations were extended to him.

8. Commendations

By separate motion duly made, seconded and carried, the Council commended R. E. Callan, M.D., for his service to the Council and the House of Delegates as Speaker, and thanked P. B. Blanchard, M.D., for his fine work on the Council and its Committee on Economic Medicine.

9. Committee Assignments and Meeting Schedule

The Chairman said that he would announce the councilors' committee assignments and the next meeting date as early as possible.

10. Adjournment

The meeting adjourned at 12 noon.

C. H. CROWNHART
Secretary

Approved:
JAMES C. FOX, M.D.
Chairman

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the wisconsin medical journal

VOLUME 66/NUMBER 8 AUGUST 1967

FESTSCHRIFT HONORING

WE NEED his example more than he needs our good wishes for the coming years. This is my personal feeling for Harry Beekman who has contributed so much to the development of Wisconsin physicians and the sciences of medicine and pharmacology.—Harold F. Hardman, M.D., Ph.D., in WISCONSIN MEDICAL JOURNAL, March 1962.

THROUGH 20 years of research at Marquette university, a dynamic little man has made tremendous contributions to the world's knowledge of blood diseases. . . . He is Dr. Armand J. Quick . . . recognized as one of the world's authorities on diseases which cause bleeding.—MILWAUKEE JOURNAL, May 16, 1954.

Harry Beckman, M.D.

Armand J. Quick, M.D.

THE STATE OF WISCONSIN has been especially fortunate to have within its boundaries two such distinguished medical scientists and disciplined physicians as Doctors Harry Beckman and Armand J. Quick of Milwaukee. It is a distinct privilege to recognize them for their many years of dedicated research and teaching at Marquette University School of Medicine. Although each has excelled in a separate field—Doctor Beckman in pharmacology, Doctor Quick in biochemistry—it is appropriate to identify them as an illustrious pair who has had tremendous influence in the development and progress of Marquette University.

These special issues—July and August—contain a number of scientific articles written by several of their students and colleagues at the request of the editors. Letters of tribute, their bibliographies, and significant honors also are recorded in appreciation of the high esteem so deserving to these two men.

The Editors and Editorial Board wish to thank all those who assisted in the preparation of these issues, and express sincere best wishes to Doctors Beckman and Quick.

V. S. FALK, M.D., Edgerton
Medical Editor

C. H. CROWNHART, Madison
Managing Editor and Secretary of the State Medical Society of Wisconsin

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Editorial Director

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Editorial Board

Present Status of Ganglion Blocking Drugs

By JAMES G. HILTON, Ph.D.
and JOHN C. HANCOCK, M.S.
Galveston, Texas

■ DESPITE THE FACT that Langley and Dickinson[1] recognized the stimulant and blocking effects of nicotine on the ganglia as early as 1889, it has been only within the past twenty years that our knowledge of these agents has expanded and that useful ganglion blocking agents have been developed. The first chemical substance marking the current development of knowledge about ganglion blocking drugs is tetraethylammonium chloride or iodide. This substance was recognized to produce a fall in blood pressure in 1914 by Burn and Dale,[2] but the ganglion blocking properties were not described until the work of Acheson and Moe[3, 4] in 1945 and 1946. These investigators demonstrated that the primary site of action of tetraethylammonium salts was on the ganglia of the autonomic nervous system and that by producing a blockade at this site, these agents were capable of lowering the blood pressure. However, because of the short duration of action of these substances and the fact that they were not effectively absorbed following oral administration, tetraethylammonium salts remained primarily a laboratory tool and a laboratory curiosity.

Shortly after the studies on tetraethylammonium, Paton and Zamais[5] investigated the pharmacology of a series of polymethylene bis-trimethylammonium salts. The results of this investigation showed that when the methylene chain contained 5 or 6 carbon atoms, the agent possessed ganglion blocking properties and when the chain length was extended to 10 or 12 carbon atoms the agent possessed blocking properties at the myoneural junction. As the result of this investigation, the bis-trimethylammonium salt containing 6 methylene groups was more completely studied and developed into a useful ganglionic blocking drug.[6] This drug became known as hexamethonium. Studies on this agent showed that it possessed almost no side effects other than those which resulted from the blockade of transmission in the ganglia of the autonomic nervous system. Because of this ganglionic blockade, hexamethonium was proposed as a drug useful in lowering blood pressure. The principal undesirable property of this drug was the poor and unpredictable absorption which required parenteral administration for full realization of its action.

The development of a satisfactory ganglionic blocking drug spurred additional investigations into this field and a search for other agents similar to hexamethonium which could be used for ganglionic blockade. As the result of these investigations, a number of ganglionic blocking agents were developed. The most popular of these have been pentolinium developed in 1953,[7] chlorisondamine developed in 1955,[8] and mecamylamine developed in 1956.[9] All of these substances appear to be well defined in their action and possess few side effects other than those which could result from blockade of the autonomic ganglia. These ganglion blocking drugs differ from hexamethonium in their absorption from the gastrointestinal tract, their potency, and their duration of action.

FESTSCHRIFT

WISCONSIN MEDICAL JOURNAL

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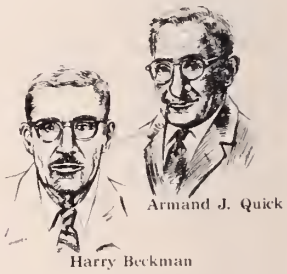

Pentolinium, chlorisondamine, and mecamylamine are all effectively absorbed from the gastrointestinal tract and may be administered orally. Based upon the oral dosage, pentolinium is approximately two times as potent, chlorisondamine is approximately five times as potent, and mecamylamine is approximately twenty times as potent as hexamethonium.[10] Pentolinium has approximately the same duration of action as hexamethonium but chlorisondamine and mecamylamine have a much longer duration of reduction of blood pressure. Paton and Zamais,[8] in

From the Department of Pharmacology and Toxicology, University of Texas Medical Branch.

their studies of hexamethonium, pointed out that there was a differential sensitivity of the various ganglia to this particular drug, and that different doses were required to produce a complete ganglionic blockade of each ganglia.

With the development of the more potent ganglion blocking agents, it was considered that if a sufficient dose of a ganglion blocking drug were administered, total blockade of ganglion transmission could be achieved. Evidence supporting the blockade of ganglion transmission was the failure of stimulants such as nicotine and DMPP to elicit a response and the apparent blockade of vasomotor reflexes in the experimental animal. Recent investigations, however, have begun to question the completeness of ganglion blockade achieved with the classical ganglion blocking drugs.

The first evidences of incomplete blockade were the reports of Root[11] and Pardo et al[12] of studies carried out using tetraethylammonium chloride as a ganglion blocking drug. Root reported that following blocking doses of tetraethylammonium chloride, pilocarpine produced an unexpected pressor response. Pardo et al reported that tetraethylammonium would block sinus node acceleration resulting from preganglionic stimulation but would not block the inotropic or chronotropic effects upon the A-V node or ventricles.

Additional studies with hexamethonium and the other ganglion blocking drugs have supported this view of incomplete blockade. These studies have been in three different areas. The first of these was the elevation of the blood pressure produced by the administration of a dose of neostigmine following ganglion blockade. Both Hilton[13] and Long and Eckstein[14] demonstrated the existence of this pressor response and its sensitivity to blockade by doses of atropine. Fenner and Hilton[15] have extended this observation of the neostigmine pressor response to show that certain reflexes such as the pressor response to occlusion of the common carotid arteries are active during neostigmine action, other ganglion responses such as the blood pressure elevation elicited by DMPP or the contraction of the nictitating membrane elicited by preganglionic electrical stimulation remain blocked.

The second area of investigation giving evidence of ganglion transmission not blocked by hexamethonium-like agents was the observation of an asynchronous electrical discharge which could be elicited in ganglia pretreated with classical blocking agents by the administration of a cholinesterase-inhibiting substance. Volle[16] demonstrated the existence of this asynchronous electrical discharge in the postganglionic nerves following the administration of DFP. He further showed that this discharge was not blocked by the administration of hexamethonium but was blocked by small doses of atropine. Takeshige and Volle[17] extended this observation to show that a similar electrical discharge could be produced with neostigmine, another cholinesterase inhibitor.

The third indication of incompleteness of blockade was the development of ganglion stimulant substances which were potentiated rather than blocked by the classical ganglion blocking drugs. The first of these unique ganglion stimulant agents was 4-(m-chlorophenylcarbamoyloxy) - 2 - butynyltrimethylammonium chloride (McN-A-343) described by Roszkowski[18] in 1961. Later Franko et al[19] reported that N-benzyl-3-pyrrolidyl acetate methobromide (AHR-602) acted in a similar manner.

These three separate areas of investigation have indicated the incompleteness of the blockade produced by classical ganglionic blocking agents and suggested that a closer look at the autonomic ganglia should prove profitable.

The portion of the ganglion transmission not blocked by classical agents proved to be of great interest because in all of these studies reported the substances and conditions stimulating the ganglia were sensitive to very small doses of parasympatholytic agents similar to atropine. Since that portion of the ganglia blocked by hexamethonium and similar agents is stimulated by nicotine and it had been shown that, in addition to the previously named substances, muscarine would also produce a stimulation of the autonomic ganglia which is blocked by atropine, it was suggested that the ganglia of the autonomic nervous system have two different types of receptive sites; one type referred to as the nicotinic sites and the other referred to as the muscarinic sites.[20]

The existence of these two types of receptors has been demonstrated; however, the majority of the experiments in which these receptors have been shown to exist depended upon either prior sensitization of the ganglia

or the administration of an exogenous stimulating agent. It has been only recently demonstrated that the dual transmission of autonomic ganglia was a naturally-occurring phenomena and that in the intact animal there continued to be a significant transmission under physiologic conditions. Hilton and Steinberg[21] have demonstrated that a portion of the peripheral vasoconstriction elicited by either increased intracranial fluid pressure or by occlusion of the common carotid arteries[22] is not blocked by hexamethonium-like ganglion blocking agents. This unblocked reflex vasoconstriction is similar to other muscarinic ganglion responses and is blocked by small doses of parasympatholytic drugs. Both Flacke[23] and Brown[24] have also demonstrated muscarinic ganglionic transmission in the autonomic fibers supplying the heart. Like other muscarinic transmission, these responses are unaffected by classical ganglion blocking drugs but are atropine-sensitive.

Thus, in a period of approximately twenty years investigators have developed a series of drugs thought to be capable of blocking transmission through the ganglia. Although the present evidence suggests that these agents do not produce a complete blockade, the results of studies using the classical agents have added to our knowledge of ganglionic transmission and the mechanisms of regulation of blood pressure.

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CLINICAL CENTER STUDY OF PATIENTS WITH CHYLOUS ASCITES

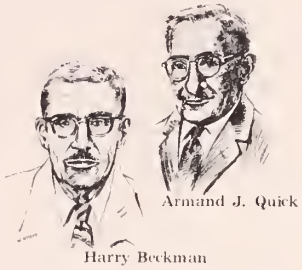
The cooperation of physicians is requested in the referral of patients for a study of chylous ascites being conducted by the Metabolism Branch of the National Cancer Institute at the Clinical Center of the National Institutes of Health in Bethesda, Maryland.

Of interest are patients with chylous effusions including those with effusions secondary to congenital lymphatic abnormalities, trauma, localized or diffuse retroperitoneal disease (including pancreatitis) and neoplasm. Studies will be directed at determining the relationship of ascites to lymphatic abnormalities, immunological defects, serum protein depletion, and protein-losing gastroenteropathy.

Selected patients will be admitted to the Clinical Center and receive full diagnostic work-up. Upon completion of their studies, patients will be returned to the care of the referring physician who will receive a full report of the studies done. Where possible, recommendations for therapy will also be made available to the referring physician.

Physicians interested in having their patients considered for admission to this study may write or telephone: WARREN STROBER, M.D., or THOMAS A. WALDMAN, M.D., Clinical Center, Room 4-N-110, National Institutes of Health, Bethesda, Md. 20014; telephone: 656–4000, ext. 66480 (Area code 301).

FESTSCHRIFT



WISCONSIN MEDICAL JOURNAL
JULY/AUGUST 1967

Social and Vocational Rehabilitation of Hemophiliacs

By PIERRE IZARN, M.D., Montpellier, France

■ THE PRINCIPAL preoccupation of doctors who take an interest in hemophiliacs, until these last years, has been to stop the hemorrhages that endanger their patients' lives and to avoid the setting in of a major physical disability. Transfusions of blood, plasma and plasma fractions and modern methods of orthopedic treatment have permitted this double objective to be attained. Hemophiliacs now reach adult age; they are desirous of obtaining their autonomy in society and to be integrated into the economic world. The hemophiliac, like any other physically handicapped person who possesses normal intelligence, has a right to exercise a profession adapted to his physical means, to his intellectual capacities and to his tastes. But to acquire a professional qualification and to obtain and keep a job, the hemophiliac finds himself in a position of inferiority from adolescence onward. Society should therefore help him, especially when he cannot rely upon his family. Everything possible must be done so *that the physically handicapped hemophiliac does not become a professionally handicapped man.*

TABLE 1—*Statistics of adult hemophiliacs of the Montpellier Hematology Institute (1966)*

Number	Hemophiliacs exercising a suitable profession	Hemophiliacs exercising an unsuitable profession	Inactive hemophiliacs
37	24	7	6

If at the end of his studies, when he is between 15 and 20, the professional training is totally neglected, the hemophiliac risks falling into one of the two, equally disastrous, situations that will now be described.

The first is maintenance in a state of complete inactivity. The hemophiliac lives upon his invalid's allowance; he stays with his family or is admitted to a hospital as a chronic case; he loses the inclination to work, resigns himself to idleness, and often does not try to get out of his condition as a dependent. On 37 adult hemophiliacs examined at the Hematology Institute of Montpellier, 6 had no professional activity (Table 1).

The second situation frequently encountered (Tables 1 and 2) is the hemophiliac's exercising a profession for which he is physically unfit. These spirited young men are eager to work but their activity is interrupted at any moment by articular or muscular hemorrhages that result from the very exercise of their professions. Sooner or later they will be obliged to stop working owing to these long periods of compulsory rest (Table 3). The only solution for them is to learn another profession. This is possible in a professional reeducation center for adults. We cite here a few of the occupations that hemophiliacs themselves recommend not to undertake: farmer or agricultural worker, warehouse worker, factory worker in plastics, worker in a wood veneering factory, locksmith, plumber, automobile salesman, driving school instructor, and bookstore clerk.

TABLE 2—*Survey of the profession of adult hemophiliacs of the French Association of the Hemophiliacs (1966)*

Answers	Working answers	Hemophiliacs exercising a suitable profession	Hemophiliacs exercising an unsuitable profession
59	56	41	15

On the other hand, when the hemophiliac —thanks to the exercise of an occupation compatible with his state—is successful in finding a place in society and when he has

TABLE 3—*Period of disability in the course of the year 1965 of some hemophiliacs excercising unsuitable occupations (survey by the French Association of the Hemophiliacs, 1966)*

Profession	Number of days
Warehouse worker	275
Farmer	140
Farm worker	136
Press fitter	101

French Association of the Hemophiliacs, and Montpellier Hematology Institute (Director: Professor P. Cazal)

acquired complete financial autonomy, his behavior changes radically; he becomes an active individual, determined to dominate his state of physically handicapped. Moreover, the hemophiliac is able to take better care of his health, to spare a few hours a week for muscular reeducation, the hemorrhages are more widely spaced. His health improves.

Thus, the professional training, the ultimate step of the instruction of the hemophiliac is of capital importance. Upon this depends in a large part, the health and the future life of the hemophiliac in the course of his adult life.

A. The problems set by the choice of a profession

(1) It is evident that for the choice of the profession *the form the illness takes, whether severe or attenuated, and the nature and the gravity of the motor handicap* should be taken into consideration.

Generally speaking, the hemophiliac must not be exposed to falls, trauma, or superficial wounds. Strenuous efforts are forbidden to him owing to the weakness of his musculature. For this reason all professions dealing with wood, metals, and construction, as well as the occupation of farmer or agricultural worker, are to be avoided. Because of recurrent hemoarthritis in the knees, all the occupations which necessitate moving about a great deal or prolonged standing such as store clerk or hairdresser will be excluded. A *sedentary occupation*, carrying a large number of hours of work sitting down, is recommended.

However, in the particular case of the attenuated hemophiliac, it is possible to be less strict and permit a choice of occupations which carry some risks such as that of bookbinder or tailor, or those which entail walking or involve some physical efforts such as agricultural adviser, gardener's help, radio repairman, architectural designer, or business machine operator.

On the other hand, the severe afflictions of the elbow articulations which completely prevent pronation and supination are hardly compatible with the exercising of occupations which necessitate great precision and some speed of hand movements such as that of cable fitter in electronics or watchmaker.

(2) *The level of instruction* is a factor which intervenes in an essential way in the choice of profession. The intellectually gifted hemophiliac, who has carried his studies a long way and has obtained university degrees, easily finds work. Besides, in all countries we know hemophiliacs who have had brilliant careers. But, the hemophiliacs whose elementary education has been neglected and even those, finishing primary school and not having been able to follow secondary education, between 11 and 15, have an extremely limited choice of professions. *A good scholarship is the indispensable condition to the acquisition of a solid professional qualification.*

(3) For the choice of profession it is necessary to take into account *the employment market and the employment previsions for the next ten years.* From here on, we know that the needs for nonspecialized administrative clerks will diminish. The liberal and artisanal professions will develop very little. Yet, there will be need for junior executives, engineers, and qualified technical agents.

B. List of professions which might be held by hemophiliacs

(1) LIBERAL PROFESSIONS AND MANAGERIAL STAFF: Teacher, engineer, chartered accountant, tax adviser, art or stamp appraiser, official doctor, biologist, psychiatrist, laboratory or drugstore pharmacist, editor, librarian, journalist, artist-painter, real estate agent, lawyer, notary, attorney, bailiff.

(2) OFFICE WORK: *Bookkeeper's assistant, accountant*, translator, proofreader in printing plants, secretary, shorthand-typist, stenotypist, telephone operator, telegrapher, *statistician*, bursar, court clerk, notary clerk, lawyer's clerk.

(3) EMPLOYMENT AS INDUSTRIAL WORKER OR CRAFTSMAN: Watchmaker, jeweller, optician, worker specialized in lens-making, artist-photographer, bookbinder, dental prosthesis technician, electrician, standardizer of measurement and control apparatus, cable fitter in professional electronics, radio-electrician, electrician, radio-telegraph operator, *architectural designer*, industrial designer, advertising designer, electrical designer, *designer in electronic construction*, biology or chemistry laboratory technician.

This list has been composed by reference to the nomenclature of individual activities at the French National Institute of Statistics

and Economic Studies and after having consulted hemophiliacs on the occupations they exercise.[1, 2, 3]

The occupations that could be recommended depending upon the employment previsions are in italics. This list is not exclusive, and certainly in the future the progress of automation will make it possible for the physically handicapped to occupy new positions in motor-car factories or smelting works which require no muscular efforts but concentrated attention and technical knowledge.

C. The forms of professional education

How many hemophiliacs acquire professional qualification?

Education by correspondence is particularly valuable for accounting and secretarial specialties; it allows those interested in electronics to complete their notions in arithmetic, algebra, geometry, electricity, and electronics. It could be used to advantage by a boy with the help of a tutor or placed in a medically supervised vocational boarding school for hemophiliacs.

Hemophiliacs may also enroll as day students or semi-boarding students in the secondary technical school (lycée technique) located in the city in which they live. This is a solution which keeps the young man within his family. Furthermore, hemophiliacs who are admitted into these medically supervised vocational schools located in the proximity of a secondary technical school are also able to benefit from this education. Such an arrangement has been organized at the medically supervised vocational boarding school of the French Red Cross Savoie, near Chambéry, where hemophiliacs from ages 16 to 20 are accepted.

An original teaching formula in accounting and secretarial training has been attempted with success in this very establishment: the young people have theoretical instruction in the mornings and in the afternoons they receive on-the-job training in the business concerns of Chambéry. In this way, the young hemophiliacs do not live in a vacuum and they have daily contacts with the everyday problems that they will come across in the course of their professional careers.

Considering the small number of hemophiliacs—there are 1600 in France—it is difficult to create establishments reserved for hemophiliacs where the diverse technical specialties that we have listed would be taught. Hemophiliacs should benefit from what has already been done for the physically handicapped, and a formula suitable to adults consists of entering the hemophiliac into a professional *readaptation center open to the physically handicapped.* This is possible if the doctors of the Hematology Institute located in the proximity of the school are prepared to take the hemophiliac into their care in the case where the least hemorrhagic accident should occur. This collaboration has been in effect since 1954 between The Professional Reeducation Center of Montpellier–Celleneuve, created by the Social Security regional office and the Montpellier Hematology Institute. The courses to which the hemophiliacs are admitted are those in accounting, electrical equipment installation, radio repair, cable fitting and assembly in electronics, fitting and design.[4] The students are boarders, which keeps them within a permanent atmosphère of work and eliminates the dangers involved in commuting. The results so far are excellent. Yet, whatever their specialty, it has been shown indispensable to make all the students take three months of schooling, called "refresher course": algebra, geometry, electricty before attending classes in electronics; French and mathematics before entering the classes in accounting.

D. The employment of the hemophiliac and his integration into the workday world

When the hemophiliac has obtained a professional qualification, he begins to look for employment.

Wage-earning jobs are preferable to independent professions. The latter do present advantages: they are exercised in the home of the hemophiliac and they leave him more free time, but they do not carry the security of a salary. Prolonged disability could endanger the activity of a small craftsman or of a commercial enterprise. Also, no one is protected from competition.

Finding a wage-earning job is not easy. The family is sometimes successful through its acquaintances. Certain readaptation centers—the one in Montpellier, for example—take on the responsibility of finding work for their trainees. The hemophiliac associations can help their members by publishing want ads and in constituting a card index

of those enterprises which are likely to hire hemophiliacs.

In France, the law of November 23, 1957, obliges business enterprises of more than 10 persons to accept a minimum percentage of handicapped workers of 3 per 100 in their personnel. This law, which is currently applied, will certainly favorize the placement of professionally qualified hemophiliacs.

It is desirable that the hemophiliac enter an enterprise where he will not be held responsible for the more or less prolonged absences brought about by hemorrhages. We think that as soon as he is taken on, it is necessary that the head of the enterprise should be informed of the state of health of his employee. Certain hemophiliacs have revealed to us that they have only been able to obtain employment by hiding their illness. In the actual state of the legislation in France, this is not an attitude to be recommended, especially if the hemophiliac is seriously handicapped.

Office jobs offer advantages as compared with industrial jobs; they may be found in all cities and even in small towns. This permits the hemophiliac to live for some time with his family. Moreover, secretarial and accounting work can be pursued at home during periods of disability; the hemophiliacs can show in this way goodwill and eagerness for work.

The positions as technical specialists are generally found in the industrial enterprises. The hemophiliac is consequently obliged to leave his family and to move to the suburbs of a large city. Finding a flat close enough to the factory, the organization of medical care, and free-time occupations are problems that can only be resolved with the help of a social service. Young workers' homes often help the hemophiliac to adapt to his new life.

There is a category of hemophiliacs whose physical handicap is so crippling that they cannot work with healthy subjects; fortunately they are not very numerous. They may be placed in contact with those enterprises which distribute work to be done at home: the making of paper caps or streamers, lamp shades or basket making using plastic fibers. Another formula consists of placing them in *protected workshops* that are subsidized by the state where the employees are all handicapped workers; there are 78 of these in France. This formula is preferable to complete inactivity. But we believe that placing the hemophiliac in an enterprise where mentally handicapped are accepted is to be avoided.

Repeated hemorrhagic accidents constitute one of the major difficulties encountered by hemophiliacs at work. They are responsible for an involuntary absenteeism which business heads fear. In fact, a recent survey of adult hemophiliacs in France proves that in 41 hemophiliacs exercising professions adapted to their condition, 32 have stopped working for less than 40 days in the course of the year 1965; only 9 were disabled for a longer time.

In any case, an enterprise director will overlook the inconvenience that these absences mean for him if his employee is highly qualified. It is for this reason that the hemophiliac, perhaps more than any other physically handicapped whose motor infirmity is permanent, will profit by continually improving in his profession and acquiring technical and theoretical knowledge of as high a level as possible. This "outclassing" will permit him to compensate for his handicap and to maintain, in spite of all the difficulties, the position in which he has been able to make himself appreciated for his conscientiousness, his competence, and his assiduity.

SUMMARY

Hemophiliacs should be directed toward sedentary occupations which do not demand physical efforts. A list of these occupations is presented. The wage-earning jobs will be preferable to independent professions. Professional training can be acquired by correspondence courses, in a secondary technical school, in a medically supervised vocational boarding school for hemophiliacs, or in a professional readaptation center for adults. The problems set by the employment of the hemophiliac and his integration in the workaday world are then discussed.

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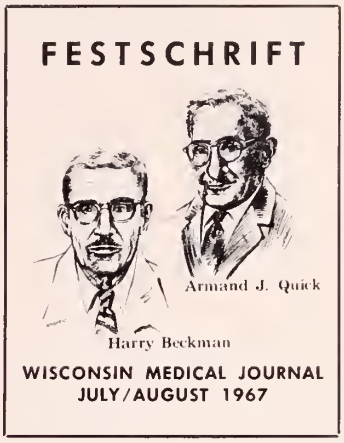
Factor V and the Prothrombin Complex: Its Titration and Significance in the Prothrombin Time



By RENE HONORATO, M.D. and V. VARGAS, M.D.
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■ TECHNIQUES USED to titrate Factor V[1-3] are based on the recovering of the prothrombin time of stored plasma mixed with adsorbed patient's plasma. The reagent used for the titration, either 15 or more days stored plasma or 24 hours heated plasma to 37° C, is not free from the factor to be titrated, and Factor V is not the only factor altered in plasma during storage.

Moreover, prolonged prothrombin time of Factor V deficient stored plasma, does not normalize completely after adding human fresh adsorbed plasma.

The technique we used has no other source of Factor V than patient's plasma. With this technique, the influence of increasing concentrations of Factor V mixed with 100% of the prothrombin complex, and influence of increasing concentrations of the prothrombin complex mixed with 100% of Factor V on the prothrombin time were studied.

On the other hand, very small amounts of thrombin are produced at the very early moments of blood clotting. That thrombin that is not enough to clot fibrinogen, may be enough to activate some factors, such as Factor V.

It was interesting to study the influence of those very small amounts of thrombin, either on Factor V (adsorbed plasma) or on the prothrombin complex (citrate eluate from the precipitate of the adsorbed plasma).

MATERIALS AND METHODS

Adsorbents. Tricalcium phosphate and purified barium sulphate were used. Molarity of $Ca^3(P04)2$ was obtained by heating a volume of suspension in an oven, until constant weight.

It is not safe enough to deduce the molarity just by adding water to complete the volume of the $Ca^3(P04)2$ suspension, after three or four weeks washings, as prescribed in most techniques. Washings easily remove some colloid and produce important changes in molarity.

For the titration of Factor V, patient's plasma carrying Factor V was adsorbed with purified barium sulphate, instead of tricalcium phosphate, because barium sulphate is easier to handle, but $Ca^3(P04)2$ appeared more convenient to get citrate eluate, rich in prothrombin complex.[2]

Factor V

Nine-tenths of a milliliter of fresh normal adsorbed plasma or 0.9 ml of fresh Factor V deficient adsorbed plasma (100 mg of Ba S04 per ml of plasma) represented the only source of Factor V in the reaction.

Prothrombin Complex

One volume of fresh normal plasma, from a pool of four or five plasmas, was adsorbed with tricalcium phosphate and centrifuged in conical centrifuge tubes. After washing with 5 ml saline for each milliliter of plasma, the precipitate was eluted with 0.1 ml of 0.2 M sodium citrate, for each milliliter of plasma. Therefore 0.1 ml of eluate has the prothrombin complex of 1 ml of plasma.

The smallest possible amount of Ca^3 (P04)2 necessary to remove Factors II, VII, IX, and X was used. Most of the time a 0.004 M final concentration in plasma was enough.

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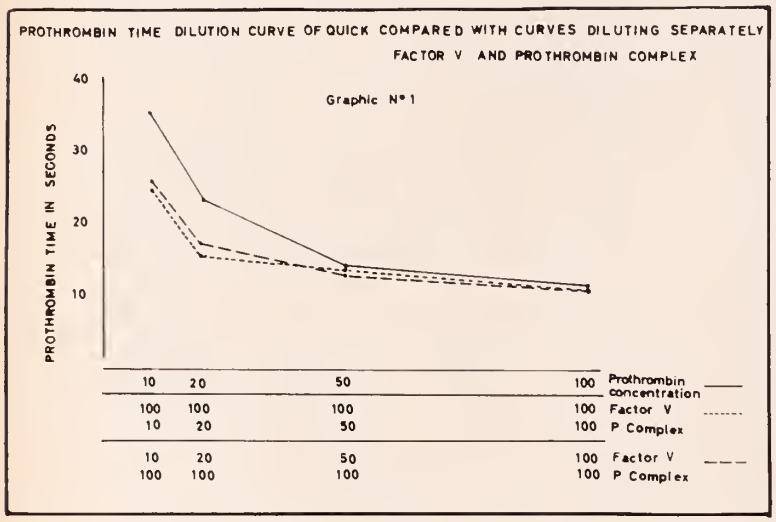
Table 1

THROMBIN ACTIVATION OF FACTOR V AND ITS INFLUENCE ON THE PROTHROMBIN TIME

Table N° 2

	PROTHROMBIN TIME IN SECONDS			
	100 V+H_2O 10PC	100 V+T 10PC	100 V 10PC+T	10V+T 100PC
	27.0	14.0	20.0	16.0
	26.0	20.0	19.0	15.0
	27.0	18.2	28.5	22.0
	28.0	15.2	21.0	19.0
	22.8	17.9	22.5	19.0
	21.2	18.0	25.0	18.0
	31.0	16.0	26.5	20.0
	30.0	18.0	27.5	18.0
		15.5	19.5	
MEDIAN	26.6	16.9	23.2	18.5
SD	±0.36	±0.62	0.38	±0.9

PC = PROTHROMBIN COMPLEX T = THROMBIN V = FACTOR V SD = STANDARD DEVIATION



Graphic 1

The eluate was kept at —20° C, in small volumes, in order to thaw only once each tube.

Thromboplastin

Only human brain thromboplastin of 10 seconds prothrombin time was used.

That very active thromboplastin was diluted with saline, to reach a prothrombin time of 11½ to 12 seconds. That thromboplastin is a guarantee of a good reagent for titration.

Procedure

One milliliter of oxalated plasma (0.1 M sodium oxalate, 1 part for 9 parts of blood) kept in lusteroid tubes at +3° C until used is adsorbed with 100 mg of barium sulphate, to remove Factors II, VII, IX, and X; 0.9 ml of that adsorbed plasma is mixed with 0.1 n of the eluate rich in Factors II, VII, IX, an X, and the prothrombin time is controlle 0.01 M and 0.02 M $CaCl_2$ are used. Th shortest prothrombin time is checked on th standard curve obtained with increasing co centrations of Factor V and 100% of pr thrombin complex.

If increasing concentrations of the pr thrombin complex are used instead, an 100% of Factor V is maintained constan the same technique may inform about th concentration of the prothrombin comple

RESULTS

Influence of increasing concentrations Factor V and of 100% of prothrombin co plex, on the prothrombin time.

The results are shown in Table 1 ar Graphic 1.

Saline was used to dilute.

No doubt that concentrations of Factor fixed the curve of the prothrombin time.

Influence of increasing concentrations prothrombin complex and 100% of Factor on the prothrombin time.

The results are also shown in Table 1 ar Graphic 1.

Saline was used to dilute.

It is clear that the trend of the curve d pends upon the concentration of the reage which varies in the reaction.

Thrombin treatment of Factor V or prothrombin complex and its influence the prothrombin time curve.

Prior to being mixed, either Factor V the prothrombin complex were incubat with thrombin, for 30 seconds at 37° C. S hundredths of a unit of P.D. thrombin p milliliter of adsorbed plasma (Factor V) 0.03 units per 0.1 ml of citrate eluate (pr thrombin complex) were used.

Twelve minutes after thrombin was adde no clotting of plasma was observed.

Ninety seconds after mixing Factor with prothrombin complex, prothromb time was controlled. Each experiment repr sents many different plasmas. Most of e periments correspond to pools of fo plasmas.

Results are shown in Table 2 a Graphic 2.

It is evident that in this case, thromb activates the adsorbed plasma (Factor V and that it shortens the prothrombin tim

No similar results with thrombin on the ·othrombin complex were observed.

ISCUSSION

The technique described to titrate Factor has many advantages:

(1) It is easy to perform in any laboratory, and results can be duplicated, if no one step of the technique is omitted.

(2) It is a quantitative technique.

(3) Patient's Factor V deficient plasma is fresh plasma, and it is the only source of Factor V in the reaction (prothrombin time).

The old technique uses 15 or more days' ored plasma, as the basic reagent. That lasma alters its Factor V, but Factor V oes not disappear, and participates in the rothrombin time; therefore, two plasmas ipply Factor V to the reaction, patient's lasma and the normal stored plasma, it is ie equivalent of having two variables.

Results obtained by making variable the oncentration of one factor and constant that f another or the other factors are very lear.

It appears that the factor in the lowest oncentration determines the value of the rothrombin time.

Differences were observed neither in exeriments with 10% of Factor V and 100% f prothrombin complex, nor in experiments ith 10% of prothrombin complex and 100% f Factor V.

Both curves were almost identical, and ery similar to Quick's curve (Table 1).

It is interesting that the factor in the owest concentration, is responsible for the lope of the curve of the prothrombin time. ut, it is a fact that is not easy to interpret.

If inorganic substances react, the law of efinite proportions can predict the results: ie less concentrated reagent fixes the mount of product to be produced. If organic ubstances react, notion of yield must be onsidered, and the situation is much more omplicated if proteins react.

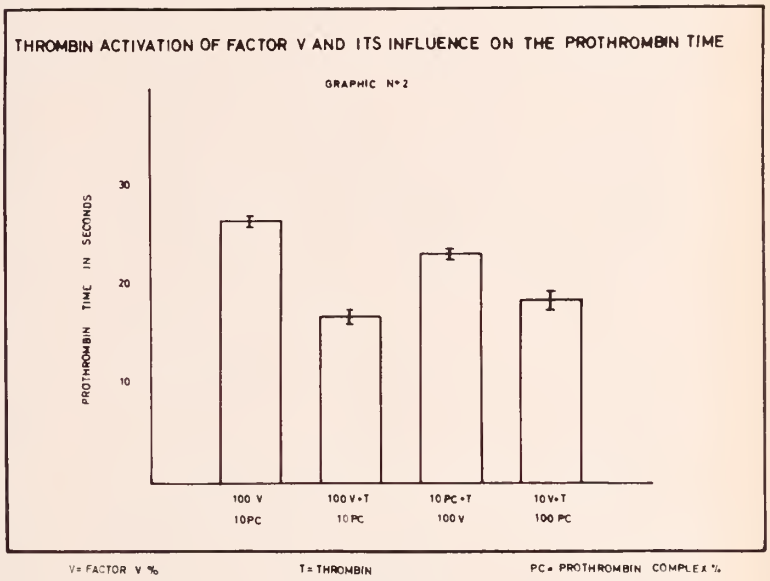
In our experiments, results had the stoichimetric aspect, but we know that it can not e the correct explanation for those findings.

Activation of adsorbed plasma (Factor ') by very small doses of thrombin, is in greement with Seegers' experiments.[4]

Table 2

INFLUENCE OF FACTOR V AND PROTHROMBIN COMPLEX CONCENTRATION ON THE PROTHROMBIN TIME
Table N°1

CONCENTRATION OF FACTOR V % / PROTHROMBIN COMPLEX %	PROTHROMBIN TIME IN SECONDS						
	100 100	100 50	100 20	100 10	50 100	20 100	10 100
	11.0	12.0	17.5	23.5	11.5	20.0	42.0
	10.2	13.2	16.0	22.0	12.0	22.5	42.0
	12.0	13.0	16.0	21.5	12.4	21.8	32.0
	10.4	13.8	16.5	23.5	14.0	20.0	31.2
	11.8	15.5	16.0	23.0	12.5	13.0	18.0
	10.6	13.0	18.5	21.0	18.5	13.5	19.0
	12.0	15.5	16.0	21.8	13.5	14.0	20.0
	11.5	12.0	16.5	25.5	13.2	15.0	22.8
	10.0	14.0	16.0	25.5	13.0	18.0	21.5
			15.0	21.0	13.8	19.0	25.0
			18.0	23.0	12.5	20.0	27.0
			18.5	39.5	12.0	17.2	22.0
			17.0	25.0	12.5	21.0	26.0
						18.4	26.2
						19.0	26.0
						17.2	23.4
							23.0
MEDIAN	11.0	14.1	16.7	24.2	13.1	18.1	26.3
STANDARD DEVIATION	± 0.27	± 0.48	± 0.3	± 0.41	± 0.48	± 0.74	± 0.56



Graphic 2

Nevertheless, Seegers activates Factor V with extremely high doses of thrombin, and in our experiments, doses of thrombin were small.

In the initial phase of normal blood clotting, very small amounts of thrombin are produced, probably not very different from doses employed in our experiments. Thus, we probably are not too far from the physiological process. On the other hand, the prothrombin complex was insensible to thrombin.

Experiments that show shortening of the prothrombin time when thrombin is incubated with Factor V, suggest that thrombin activation of patient adsorbed plasma (Factor V), may be a convenient method to get

information on the reactivity of Factor V in different diseases.

SUMMARY

A technique for the titration of Factor V is described. Influence of large or small doses of Factor V on the prothrombin complex is discussed. Activation of Factor V by small doses of thrombin is shown.

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MANDIBULO-FACIAL DYSOSTOSIS (Treacher-Collins Syndrome)

Louis E. Fazen, B.A.; Jean Elmore, B.A.; and Henry L. Nadler, M.D., from the Genetic Clinic, Children's Memorial Hospital, and Northwestern School of Medicine, Chicago, Ill., *American Journal of Diseases of Children*, vol. 113, no. 4, April 1967.

The classical signs of mandibulo-facial dysostosis include the following: (1) lack of development of the auricle, which may be associated with atresia of the external auditory canal, deformed middle-ear auditory canal, deformed middle-ear ossicles, and congenital hearing loss, (2) palpebral fissures slope downward and laterally giving the impression of the antimongoloid-shaped eyes, (3) coloboma or notching in the temporal portion of the lower lids with deficient or absent eyelashes in the medial two thirds of the lower lids, and (4) hypoplasia of the facial bones, especially the mandibular and zygomatic bones resulting in micrognathia and a "fish-like" facial appearance.

Although a considerable amount of information has been accumulated, the clinical management of this syndrome has not been clearly elucidated in American pediatric literature. To our knowledge only the reports by McEnery and Brennemann, Hunt and Smith, and Moss et al have been published in American pediatric journals. The purpose of this paper is to report a family with mandibulo-facial dysostosis in which there are ten affected members in four generations, and to discuss the differential diagnosis, treatment, and genetic counseling of this disorder.

The treatment in cases of mandibulo-facial dysostosis is facilitated by early diagnosis. Since the majority of cases have abnormal hearing, audiology tests should be performed as early as possible. The development of speech and language depends upon the child's ability to hear during the first three years of life. The child's development of speech may be improved by educating the parents to concentrate on speaking loudly and by application of appropriate bone-conduction hearing aids. Surgical procedures have been developed to correct the bone conduction defects. In cases of external auditory meatal atresia, Livingstone recommends surgical repair be undertaken at 18 months of age.

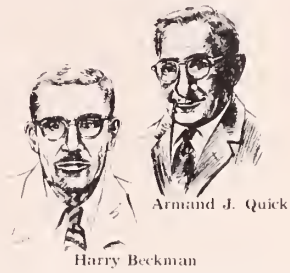
Of less immediate concern, but nonetheless of major importance are the psychological problems of adjustment of the affected individual and family. It may be possible to avoid the major behavior and psychological problems if plastic surgical reconstruction of the facial abnormalities is undertaken by the time the child enters school. The surgical repair of mandibulo-facial dysostosis may involve increased risk to the patient because of the difficulties in sustaining endotrachial intubation during the administration of general anesthesia. With the development of secondary dentition the physician may anticipate the growth of abnormally spaced teeth due to the hypoplastic mandible.

Genetic analysis of the seven families was in agreement with the general impression that the probable mode of inheritance is an autosomal dominant condition. Approximately 50% of the offspring (47 out of 90) of the affected parents were also affected. There was no significant difference in the number of males (20) and females (25) affected. Thus, if an affected person were to marry, he may expect 50% of his progeny, regardless of sex, to be affected with the syndrome. On the other hand, a completely normal sibling of an affected person will have the same chance as any other normal person (i.e., the risk of a new mutation) of producing an affected offspring. Extreme caution should be used in counseling relatives of an affected child if any of the principal abnormalities are present, as the variable expressivity found in mandibulo-facial dysostosis makes it impossible to predict the degree of involvement for any of the affected offspring.

Although no quantitative studies on the lethal effects of this syndrome have been reported, there were two abortions, three stillbirths, and four neonatal deaths in the family presented in this paper. The possibility of a lethal inheritance or a homozygous lethal condition associated with mandibulo-facial dysostosis has been suggested by Book and Fraccaro, and Rogers.

Mr. Fazen is a medical student at Northwestern University, Evanston, Ill., and the son of Dr. Louis E. Fazen, Jr., Racine surgeon, and a grandson of the late Dr. Louis E. Fazen, Sr., a pioneer Racine surgeon.

FESTSCHRIFT



WISCONSIN MEDICAL JOURNAL
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Acquired Coagulation Deficiencies Detected with the Prothrombin Time

By CLARA V. HUSSEY, M.D., Milwaukee, Wisconsin

■ THE INTRODUCTION of the one-stage prothrombin time by Quick in 1935[1] opened a new era in the diagnosis of bleeding diatheses. The prothrombin time supplied a means of differentiating the bleeding diatheses into two major categories: those having deficiency of thromboplastin precursors and those having deficiency of factor (s) affecting the prothrombin time itself. Also, for the first time, it became possible to explain bleeding which occurred with cholecystectomy.

Today it is possible to do modifications of the prothrombin time, making it specific for the various factors required in the test. These factors were actually discovered as a result of the one-stage prothrombin time. There is factor V (labile factor) described by Quick (1944),[2] factor VII (stable factor) described by Alexander,[3] and factor X (Stuart–Prower factor).[4]

Although the determination of the specific deficiencies detected in an abnormal prothrombin time can help in determining therapy, the modifications of the prothrombin time have not been widely used. In this paper I would like to illustrate the simple regimen in use at our hospital and give some of the values obtained in the study of patients.

METHODS

The basic prothrombin time was done using an acetone-dehydrated rabbit brain thromboplastin, as outlined by Quick.[5] Modification of the prothrombin time to supply an excess of factors VII and X was done by adding 0.01 ml aged serum to the test system.[5] Factor V was measured either by the method of Quick[5] or, during the past year, by the citrate eluate method[6] which we developed. The results of both procedures may be used interchangeably.

In those patients with liver disease, euglobulin lysis times were done according to the method of Sherry.[7]

Generally speaking, our approach to the bleeding patient includes an estimate of platelets, a bleeding and clotting time, and a prothrombin consumption time. The studies reported in this paper are limited to cases with abnormal prothrombin times and include nonbleeding problems where prothrombin times are done as presurgical studies or as a control of anticoagulant therapy.

RESULTS

In Table 1 the results obtained on two newborn infants are given. The most striking difference noted is the factor V activity in the second infant, the deficiency of which was correlated with the liver abnormality found at autopsy.

Cases in which there is an abnormal prothrombin time with normal factor V activity are grouped in Table 2. These cases consist of vitamin K deficiency secondary to obstructive jaundice, and cases of ingestion of antivitamin K drugs. It was noted that bleeding occurred with trauma, such as venipuncture, where the prothrombin time with serum gave results of more than 19 seconds.

Table 3 illustrates the depression of factor V accompanying the abnormal prothrombin time when hepatocellular disease is present.

TABLE 1—*Abnormalities found in two newborn infants*

Diagnosis	Basic prothrombin time (sec.)	Prothrombin time with serum (sec.)	Factor V Activity (%)
Hemorrhagic disease of the newborn	180	62	100
Hamartoma of liver	85	31	40

From the Department of Pathology, Milwaukee County General Hospital and Marquette University School of Medicine.

TABLE 2—*Abnormalities seen in vitamin K deficiency and with anti-vitamin K drugs*

Diagnosis	Patient	Basic prothrombin time (sec.)	Prothrombin time with serum (sec.)	Factor V activity (%)
Obstructive jaundice	A. B.	16	12½	100
	M. B.	118	33	100
	H. S.	68	23	100
	N. V.	44	35	80
Excessive ASA ingestion	J. B.	17	14	100
	J. S.	21	20	80
Coumadin therapy	A. E.	30	14	100
	B. B.	42	19	100
	R. M.	25	16	100
	E. Z.	18	12	90

In these cases the deficiencies consist of factors II, VII, and possibly X as well as V.

In Figure 1 we have a graphic presentation of the difference between obstructive jaundice and cirrhosis when factor V activity is plotted against the basic prothrombin time.

DISCUSSION

When a patient has an acquired bleeding problem, it is usual to order a platelet count and a prothrombin time. If the prothrombin time is abnormal, the cause remains a question. Differentation of the cause is best aided by the determination of factor V activity which will divide the cases according to presence or absence of significant hepatocellular disease. Deficiency of factor V seems to correlate with the degree of liver dysfunction. In cases where the factor V activity is less than 30% of normal, bleeding secondary to trauma, for example, will be accentuated. Whenever this degree of deficiency exists, replacement therapy using fresh blood or fresh frozen plasma has been beneficial. Additional administration above a level of 30% of normal does not correlate with clinical improvement.

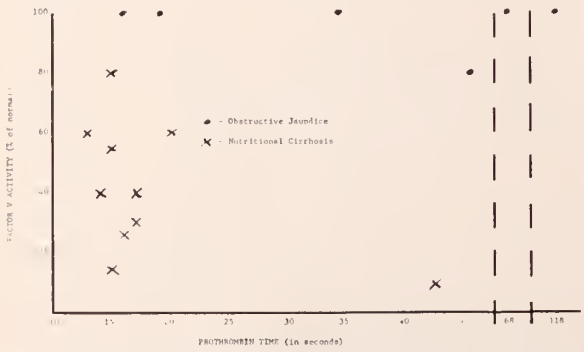

Fig. 1—Comparison of Factor V activity in patients with obstruction and cirrhosis.

TABLE 3—*Abnormalities seen with liver dysfunction*

Diagnosis	Patient	Basic prothrombin time (sec.)	Prothrombin time with serum (sec.)	Factor V activity (%)
Carbon tetrachloride ingestion	D. R.	19	16	26
Hepatitis	B. K.	33	16	40
	K. D.	17	14	25
Cirrhosis	J. S.	43	29	10
	R. B.	18	14	45
	R. D.	25	20	20
	G. J.	16	14	50

Cases where an abnormal prothrombin time is accompanied by a normal level of factor V activity (80% or more), the deficiencies (prothrombin, and factors VII and X) are those requiring vitamin K for their production. There will be a difference in the rate of response to vitamin K according to the cause of the abnormal prothrombin time. With pure vitamin K deficiency correction will occur within 6 hours. Whereas, in the presence of an anti-vitamin K drug a period of 18 to 24 hours is required. Even then, the natural vitamin K will be superior to the synthetic in correction of the prothrombin time.

When acetylsalicylic acid has been ingested, the bleeding tendency might occur before adequate anti-vitamin K activity is demonstrable by an abnormal prothrombin time. This bleeding tendency is related to the vascular effect of the drug as reported by Quick.[8]

SUMMARY

An approach to the evaluation of abnormal prothrombin times occurring in patients is outlined. Utilization of this information for patient therapy is discussed.

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Own Investigations on the Hemostatic Influence of Erythrocytes

By HENRYK A. GAERTNER, M.D., Krakow, Poland

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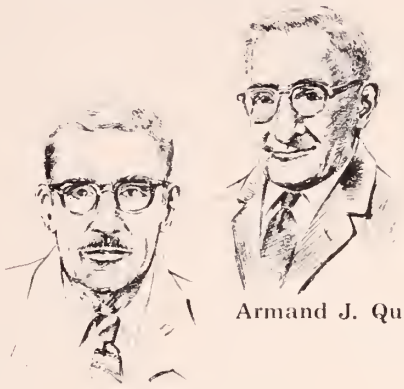

Armand J. Quick

Harry Beckman

WISCONSIN MEDICAL JOURNAL
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■ GREAT IDEAS go fast, far, and wide. Twenty years ago when I was attracted by the intricate and fascinating hemostasis problems, the name of Doctor Quick was world famous. His achievements helped not only to open many new important scientific paths but also to overcome the existing chaos of hemostasology and to reconstruct the rich mosaic of already known but so often misinterpreted facts.

The classical definition of the hemostatic system embraces the following three components: platelets, plasma, and vascular endothelium, in spite of numerous evidences of the participation of other blood cells and factors of vascular wall and other tissues. Therefore, eight years ago I began a series of investigations concerning the active and passive participation of red blood cells in coagulation processes. Once more I followed in Doctor Quick's footsteps and had the great honor and pleasure to work with him in his biochemistry department at the Marquette University School of Medicine. As a fellow in hematology of the Rockefeller Foundation for many months I profited not only by his great knowledge and experience but also shared his deep passion for science and arts.

After I returned from Milwaukee to our Polish old capital—Krakow, he often encouraged me in further research of problems interesting both of us. The present review of my investigations is a dedication to Doctor Quick as a proof of my deep gratitude and admiration of his work and personality.

From the Blood Coagulation Laboratory. Doctor Gaertner is Head and Associate Professor, Third Medical Clinic; Director is Dr. J. Aleksandrowicz, Professor of the Academy of Medicine, Krakow.

The red blood cells exert an important influence upon the coagulation of the blood. In our research we followed two directions of investigation: (1) the action of whole erythrocytes and (2) the influence of different erythrocyte preparations upon the blood clotting reactions.

The effect of *whole* red blood cells was studied in vitro and in thrombelastograph with a series of "artificial" bloods with different concentrations of erythrocytes and plasma produced from the same blood. Low concentrations of erythrocytes enhanced the coagulation in vitro. Higher concentrations exceeding the upper normal limits of the hematocrit index delayed the appearance of the gel-condition and markedly impaired the formation and consolidation of the clot, whereas the onset of coagulation (appearance of the first fibrin threads) was slightly retarded only. The clot produced in these conditions was friable, soft, and had a jelly-like consistency. In control estimations the dilution of plasma with buffer enhanced at first the coagulation and a plasma dilution of above 50% had a much less pronounced delaying effect on clotting than a corresponding dilution with red blood cells. The erythrocyte or buffer concentration did not affect the residual prothrombin times of sera produced from plasmas with added red blood cells or buffer. Addition of fibrinogen exerted a distinctly correcting influence on the above mentioned disorders of clotting and of the clot.

In thrombelastographic estimations the low erythrocyte concentrations shorten the reaction time ("r"). Those exceeding the upper limits of the normal hematocrit values progressively prolong this time. The clot formation time ("k") remains unchanged in the presence of small erythrocyte concentrations. If these concentrations exceed the upper normal limits of hematocrit, a parabolic rise of "k" is observed. The maximal elasticity of the clot ("me") decreases after addition of the minimal concentrations of erythrocytes. Linear decrease of "me" is proportional to the increase of erythrocyte concentration. In the controls the addition of physiological saline has the same, but slighter effect on "r" and "k"; the effect on "me" is very similar to that of red blood cells.

This group of results demonstrates the great significance of whole red cells for the clotting course and clot properties. This significance cannot be related only to the simple dilution of plasma with erythrocytes. In the light of these investigations the hematocrit value must be considered as an important regulator of hemostasis. Deflections from normal hematocrit values may have a compensatory effect or lead to frequent thromboembolic and/or hemorrhagic complications so often encountered in polycythemia and usually absent in simple anemia. An additional factor in these disorders represents a relative deficiency of fibrinogen in relation to the erythrocyte mass that ought to be built into the clot. The concentration of red blood cells (or buffer) does not influence the conversion of plasma prothrombin into thrombin.

The hemostatic activity of *erythrocyte preparations,* especially of the ETF (erythrocyte thromboplastic factor called erythrocytin by Quick; and because of its thromboplastic effect, erythroplastin by Gaertner and Caen) can be studied by different methods and in various clotting reactions. In most of our investigations we used the prothrombin consumption test and the thromboplastin generation test.

We detected the presence of the ETF in the eluate of the electrophoretically immobile or only slightly mobile hemolysate fraction. This fraction was different from other relatively mobile fractions containing the hemoglobin and further hemolysate proteins. The eluates of the last fractions are devoid of the ETF activity. The different erythrocyte preparations retain their ETF effect in low temperatures for a long time and lose it after contact with chloroform.

The ETF action becomes manifest after the red blood cells have been destroyed either mechanically or by means of low temperature (freezing and defreezing) irrespective of osmotic hypotonia. When the erythrocytes are suspended in increasing hypotonic sodium chloride dilutions, the ETF effect appears simultaneously with hemolysis. Initially this ETF activity rises with the light adsorption index and in inverse relation to light transmittance. The ETF action can be demonstrated in homogenates, hemolysates (obtained by freezing or osmolysis), lyophilysates (prepared from homogenates and both mentioned types of hemolysates) and electrophoretic fractions of hemolysates. The erythrocyte preparations from native (silicon technique) or citrated blood show similar ETF activity. The ETF effect has been found in human, sheep, hound and rabbit erythrocytes. (In the last ones it seemed to be essentially weaker). There was no difference in the ETF activity between the red cells of healthy persons and patients suffering from severe thrombocytopenia or Hageman defect.

* * *

In numerous experiments we estimated the action of ETF alone or conjugated with other thromboplastic factors of plasma, blood, or tissue cells. The ETF cannot replace the plasma Factors V, VII, and X in their role of activators of the prothrombin conversion into thrombin. There is no functional synergy between ETF and studied plasma factors not contained in our hemolysate preparations. The ETF (and cephalin) exert a synergistic procoagulant action in the presence of already minimal concentrations of snake venoms (Stypven, Reptilase).

In further investigations we estimated the single or coupled effect of ETF in comparison to similar actions of TTF (thrombocyte thromboplastic factor), tissue thromboplastin, and cephalin. In the thromboplastin generation test we used different concentrations of ETF (hemolysate from frozen human erythrocytes) and TTF (suspension of human blood platelets) separately or mixed together in equal volumes. Acting *alone* the increasing concentrations of ETF or TTF enhance

gradually, first stronger then weaker, the initial and the terminal yield (each after one 10 min incubation) of the test. Operating *together* ETF and TTF in all combinations of concentrations used increase both yields of the test in comparison with control reactions. Increasing ETF concentrations in the presence of simultaneously increased or decreased TTF concentrations enhance gradually, first stronger then weaker, both test yields. In the presence of increasing TTF concentrations the initial and terminal yields do not change at the lower, and decrease at the higher, ETF concentrations. When any one of the TTF solutions remains unchanged, both test yields gradually increase with progressively lower ETF concentrations (only the terminal yield sinks at higher TTF and ETF concentrations), while at all TTF concentrations the final yield falls with the increasing ETF concentrations. All these results are shown in Table 1.

The single or conjugated ETF activity appears at the lowest used concentrations of different erythrocyte preparations (beginning in some experiments with 0.01%), then increases rapidly almost linearly to a certain "optimal" concentration (5 and 10% in most of experiments). Later the increase becomes gradually smaller and in high concentrations, as they tend towards 100%, even a relative pseudo-anticoagulant effect may be observed. In the experiments using the thromboplastin generation test, the intensity change of ETF and TTF action on both test yields occurred beginning with or above the 50% concentration of ETF and/or TTF. The concentration of ETF can be expressed either as a percentage of erythrocyte mass irrespective of other preparations (hemolysate, etc.) or in weight units of lyophilysate, allowing in the last case an eventual determination of a relation between biological and weight units of the ETF.

The ETF may replace several above named thromboplastic blood cell and tissue factors in appropriate clotting reactions, especially in the prothrombin consumption test. The activity of procoagulant ETF concentrations is similar (or even rather stronger) to the same effect of TTF or cephalin and weaker than the action of tissue thromboplastin. The optimal and maximal procoagulant effect of ETF, TTF, and cephalin appears at their lower concentrations than the same in-

TABLE 1—*The effect of ETF and TTF upon thromboplastin generation*

Action	of	yields of the thromboplastin generation test (initial and terminal)
Single	ETF ↗	↗ < 50% ≧ ↘
	TTF ↗	↗ < 50% ≧ —
Coupled	ETF TTF	↗ < 50% ≧ ↓ ↓ all % ↘ [1,2]
	ETF ↗ TTF ↗	↗ < 50% ≧ ↓ ↓ < 50% ≧ ↘
	ETF ↗ TTF ↘	↗ < 50% ≧ ↓ ↓ ≧ 25% < ↘ [3]
	ETF — TTF ↗	— < 50% ≧ ↓ all % ↘ ≧50%[4] [2]
	ETF ↗ TTF —	↗ < 50% ≧ ↓ ↓ all % ↘ ≧50%[4] [2]

ETF, TTF—Erythrocyte or thrombocyte thromboplastic factor
[1] In comparison to control reaction
[2] Terminal yield at 100% of ETF and TTF equal to that of the control reaction
[3] Terminal yield does not change essentially
[4] Especially in the presence of higher TTF concentrations
↗, ↘, —: Increasing, decreasing, or unchanging concentrations respectively yields
>, <, =, all %: Higher, lower, equal to, or all concentrations expressed in percent of hemolysate or platelet suspension

fluences of tissue thromboplastin. The clotting time differences between the platelet-poor and platelet-rich plasmas are effaced by much lower concentrations of ETF, TTF, and tissue thromboplastin than by those of cephalin. The ETF and tissue thromboplastin promote stronger clotting of platelet-rich plasma than TTF and cephalin. The latter substance has a true anticoagulant activity, while the 100% concentrations of ETF and TTF exert in most experiments a relative pseudo-anticoagulant action absent in 100% tissue thromboplastin.

In conjugated action the pro-or-anticoagulant effect of ETF dominates that of TTF; thromboplastin with ETF exerts a stronger procoagulant influence than thromboplastin with cephalin which effect is stronger than the combined influence of ETF and cephalin. This is due to the predominating procoagulant effect of thromboplastin and the prevailing anticoagulant influence of cephalin. Similar explanation can be given in the interpretation of results in the group of tests where all three thromboplastic factors (ETF, thromboplastin, and cephalin) have been used simultaneously.

Recapitulating we discern following behavior of thromboplastic factors in vitro:

(1) In individual action a procoagulant effect of low concentrations and a true or pseudo-anticoagulant influence of higher concentrations may be observed.

(2) In conjugated action an addition or even a synergy between the procoagulant or

between the anticoagulant influences, as well as an antagonism between procoagulant effect of one factor and anticoagulant of the other can be demonstrated.

The second group of our investigations concerning the erythrocyte preparations brings further explications of the hemostatic influence of ETF and other factors conforming to Doctor Quick's views of the role of erythrocytin in the blood coagulation system. The procoagulant synergy of minimal concentrations of different thromboplastic factors liberated from blood and tissue cells may play, in our opinion, an important role in blood coagulation processes and become the initial or further link in the local or general formation or propagation of a thrombus.

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HAVE WRITER'S CRAMP? COMPUTER CAN NOW ELIMINATE IT

A University of Wisconsin Medical School investigator has found a way the computer can help the doctor in his examination of patients—perhaps ease his traditional writer's cramp.

Dr. Warner V. Slack, an assistant professor of medicine and computer science, has devised a method which enables a small digital computer to "interview" a physician about the results of his physical examination of the patient. The computer records the findings on magnetic tape and also furnishes printed copies for convenient reference.

Doctor Slack's object, as he points out, is not to replace the doctor with a clever machine but to let the computer help the doctor by providing a legible, accurate and complete record of his findings. The physician's interviewer is a Laboratory Instrument Computer (LINC)—a compact computer which Doctor Slack has already utilized in a project which enables the LINC to take medical histories directly from the patient.

Physical exam data collected and processed by the LINC so far, Doctor Slack says, suggests that the computerized recording method has an edge over handwriting or dictation. One physician using the LINC said he preferred the traditional handwritten physical exam write-up. But it developed he had never used a typewriter—the one mechanical skill the LINC method requires.

In the physical exam project, the LINC is programmed with a series of quantitative and qualitative questions relating to various aspects of the physical examination. For example, the computer will ask the doctor for quantitative facts, such as blood pressure, respiration and pulse. It will also permit him to type—on the LINC keyboard—his own qualitative judgments about the patient's mental status, or his findings about the patient's heart function.

The current program contains 825 questions. The maximum number the doctor would have to answer—if all findings were abnormal—is 700. Otherwise, the doctor need answer only an average of about 100 questions per patient. And that number will decline as the project is revised.

The LINC summary of the physical examination, recorded on magnetic tape, serves as a permanent record which can be utilized either in clinical research or in followup work with the individual patient. In some instances, the computer can act as a watchdog which can remind the doctor of a portion of the examination he might have omitted.

Doctor Slack was assisted in the pilot project by Dr. Ben M. Peckham, chairman of the Medical School department of gynecology and obstetrics, Lawrence J. Van Cura, a computer scientist, and William F. Carr, a statistician with gynecology and obstetrics. Residents on the gynecology service also cooperated on the project.

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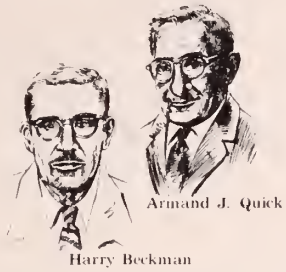

Diverse Diseases, Globulins, Plasma Cells, Russell Bodies, Foà-Kurloff Bodies, and the Thymus

A Unifying Concept

By VAUGHAN P. SIMMONS, M.D.
Philadelphia, Pennsylvania

There are many ways of studying life:

—There is the tabulation of simple facts, such as the registration of structural detail or of biochemical changes produced by an experimental intervention.—This work is safe; it is the ***book-keeping of Nature.***

—There is the descriptive characterization of complex facts, such as clinical syndromes or intricate tissue-reactions.—This work is inspired; it is the ***landscaping of Nature.***

—Finally, there is the correlation of facts into a unified system, a Science. For the explorer of Nature this yields a practically useful (though not necessarily complete or even correct) map of navigation. It helps him to remember the points he saw and to discover new ones along the roads of abstractions which connect them.—This work is creative; it may lead far astray, but apart from procreation, this is the closest man can come to the making of Nature.

HANS SELYE[1]

■ "FOÀ–KURLOFF BODIES? Never heard of them! Aren't Russell bodies degenerative products in plasma cells? What does the thymus have to do with these and what do *any* of them have to do with globulins or diverse diseases?"

Man's thymus has been given a most-favored position astride the heart. Have you, like Galen, wondered why? Have you considered the thymus to be as important as the heart? Have you known that it is a functional organ throughout life—that it is probably the only normal producer of plasma cells? You know that γ-globulin is produced by plasma cells but did you know that Russell bodies may be γ-globulin—that they are the *normally* secreted products of plasma cells? Did you know that the Russell bodies of man and the Foà–Kurloff bodies of guinea pigs are homologs? Are you aware that "diverse diseases" are linked by abnormalities of type or amount of globulin? Are you interested? Then let's go!

Since the literature on the plasma cell is, or should be well known to the experts in this field, and since it is not my purpose at this time to write a review article, I will jump over a great deal of the pertinent literature and hit only relatively few of the features which are significantly related to this presentation; if you are interested, the references cited will lead you more deeply into the subject.

I will not attempt to establish priorities here and apologize to those who may feel that they saw it first, whatever "it" may be. For myself, I claim to have discovered nothing new, for in its turn, each "discovery" has either been a re-discovery or I expect that it will be if I search long enough in the library. But it has been and continues to be great fun to do the detective work necessary and to attempt to emulate Selye in the creative work of correlating facts into a unified system. For, once understood, Nature's creations are invariably simple. Man, because of his limited ability to comprehend, often sets up vastly complicated systems which, in themselves, may require the major portion of a lifetime to be mastered. So let's try to cut through the morass and, like the child in Hans Christian Andersen's tale of "The Emperor's New Clothes," see things as they really are.

Doctor Simmons is Medical Director of The Fidelity Mutual Life Insurance Company.

The Thymus as a Source of Blood Cells

Some readers will be surprised to learn that many hundreds of research articles had appeared on the subject of the thymus prior to the recent wave of interest and that many of the "new" discoveries are not really new at all; they had simply been forgotten. Many researchers around the turn of the century and long before had recognized that the thymus was a very significant source of leukocytes but, alas, most considered the thymus to be an organ of infancy and childhood and, therefore, limited in importance in the total scheme of things. We will be back to a discussion of this basic fallacy later for it is important to understand that the thymus is a functional organ throughout life.

Red blood cells, lymphocytes, plasma cells, and various myelocytic forms have been described as originating in the thymus and numerous observers have commented on its cell-engorged draining lymphatics. Meticulous counts of the mitotic activity within the organ, experiments with radioactive tracers on the nucleic acid turnover, and other studies have all led workers to conclude that the thymus must be a major source of blood lymphocytes. In spite of all the evidence which has accumulated indicating that this must be true, there are "authorities" who say there is still not sufficient reason to believe that cells actually leave the thymus. Rather than prolong the debate, I refer you at this time to Figure 1 which shows the detail of a thymic lymphatic as it originates at the periphery of a lobule where it is in contact with the septum. The endothelium of the lymphatic vessel appears as a continuation of the peripheral lobular margin. Thymic lymphocytes can be seen entering the vessel and the two minute valves leave no doubt as to the direction of cellular movement.

It has been known for over fifty years that there are no afferent thymic lymphatics but, in spite of this, few modern interpreters have been willing to concede that cells seen in interlobular lymphatics are actually leaving the thymus. Here, another great error in basic thinking was chiefly responsible and there will be more on that later. For an additional low-power view of the area from which this photograph was taken, please refer to my 1965 paper.[2]

Figures 1–12 appear at pages 358 and 359.

There is an abundance of evidence to reinforce the view that the thymus is a very important producer of leukocytes but I shall not review it here in view of space limitations. Suffice it to say that while work has been held back for seeming want of a clear-cut demonstration that cells do leave the thymus, there has been no lack of circumstantial evidence to prove the point.

The Nature of Plasma Cells and Russell Bodies

Plasma cells are mononuclear, lymphoid cells which develop ergastoplasm, synthesize protein and liberate it to the exterior of the cell as fluid, a gel or as crystalline material. All three modes of excretion have been observed by many people; I have personally observed only the first two. Thiéry[3] has published some excellent photographs of the crystals.

The nucleus of the mature plasma cell is characteristically eccentrically placed and this is particularly so when a substantial amount of cytoplasm has developed. The cytoplasm is deeply basophilic in young forms and contains a heavy concentration of ribonucleic acid; as an acidophilic "secretion" accumulates within the cytoplasm, the basophilic RNA disappears in a reciprocal manner. At times, the secretion accumulates in large globules, either by coalescence of small ones or enlargement of single spheres. Electron microscopy by Braunsteiner and Pakesch[4] and others has shown an abundant network of lamellar ergastoplasm—structures present in all secretory cells; some of the globules are apparently still within these basophilic, RNA-rich membranes which can be seen in many preparations.

It was recognized at least as early as 1910 by Hal Downey[5] that the temporary retention of secretion by plasma cells is a perfectly normal phenomenon.

We do not consider it unusual or abnormal for mucous secreting cells to temporarily retain and release fluid and this is equally an accepted norm for other fixed glandular cells. The idea of a "unicellular gland" was also expressed by others who were well aware of what was taking place without fully appreciating its significance.

The appearance of the secretion within the cell is often so striking that it was almost inevitable that it should attract attention and be given a special name. Although such

cells were noted and described at least as early as 1875, Russell's[6] designation of them in 1890 as characteristic organisms of cancer attracted widespread attention and stimulated a great flurry of activity, much as did Hargraves, Richmond and Morton's[7] observations and conclusions regarding the so-called LE cell, about which I shall have more to say later.

Russell concluded that his "bodies" were fungi but, because of their staining characteristics with a nuclear dye, considered the possibility that they might be nuclei in spite of their "perfect roundness and homogeneous hyaline-like structure." The literature from 1890 on contains numerous references to Russell bodies or Russell fuchsine bodies and, while much has been learned about them, there is still confusion on the part of many authors as evidenced by the multitude of terms encountered. Some of them are LE cell, LE-like cell, Mott cell, morula cell, foamy cell, "Schollenleukozyt", cryoglobulin-inclusion cell, infiltration cell, globule leucocyte, colloidocyte, amyloid-inclusion cell, thesaurocyte, storage cell, flaming cell, basket cell, and so on. You may wish to argue about some of these but I suggest that you finish the paper first.

Pearse,[8] in a magnificent paper, demonstrated that the protein secreted to form Russell bodies is a glycoprotein, Grundner–Culemann, and Diezel[9] added to this a lipoid component on the basis of their studies. The presence of immunoglobulin had been anticipated more than fifty years ago but clear proof awaited the demonstrations by Bing and Plum,[10] Kolouch,[11] Fagraeus,[12] Coons, LeDuc and Connolly,[13, 14] Ortega, Mellors and Korngold[15, 16] and others. Of particular pertinence to this thesis is a quote from Ortega and Mellors:[15] "The findings indicate that γ-globulin is formed in the germinal centers of lymphatic nodules and in the cytoplasm of mature and immature plasma cells of two types—those with and those without Russell bodies." Mellors'[17] very recent paper on immunocytes and immunoglobulins summarizes a great deal with the statement: "Cytoplasmic basophilia (and pyroninophilia), a characteristic of the plasma cell family from 'blast to mature cell, gives way to acidophilia when Russell bodies with unusually dense concentrations of (basic) immunoglobulins are formed."

It has been my good fortune to have worked with and under the direction of Harry Beckman, an inspiring teacher and prodigious worker, possessed of the greatest intellectual drive and capable of the most intense concentration of anyone I have ever known. It is a pleasure to dedicate this paper to him and to Armand Quick, a close personal friend of long standing.

V. P. SIMMONS, M.D.

While the lion's share of the characterization studies have dealt with the production of γ-globulin by plasma cells, the production of other glyco- and lipoprotein moieties appears to be a certainty. Numerous studies have related the presence of large numbers of plasma cells to simultaneous increases in α and β globulins as well as the heterogeneous γ-fraction.

The chemical nature of the Russell bodies of mature plasma cells is such that the secretion is PAS (periodic acid-Schiff) positive. Pearse's description echoed that of the older workers but added the touch of modern cytochemistry: "If a tissue is chosen in which plasma cells containing Russell bodies are present in addition to the ordinary types, then intermediate states can be found between the plasma cell with faintly periodic acid-positive cytoplasm and one containing the fully developed Russell bodies. These states are best seen in sections stained by periodic acid after ribonuclease.

"The stages of development appear to be as follows. The faintly positive plasma cell, which is usually normal in size, first enlarges and becomes more strongly positive. The contained material then becomes finely granular with a decrease in the total intensity of staining. The granules enlarge, increasing until they become globules the size of adult red cells or larger, and the intensity of staining rises simultaneously. Finally, the cell may be so full of globules and their colour so deep that they appear to coalesce. In some cases, the process appears to stop at the stage of a cell scarcely larger than the normal plasma cell, with bright red non-granular cytoplasm. These cells appear in the majority of chronic infective conditions, and with haematoxylin and eosin staining look like eosinophils with unlobed nuclei." All of which is precisely so but said so much better than I could do it!

Foà–Carbone–Kurloff Bodies

At about the same time that Russell was concerning himself with the "characteristic organism of cancer" in man, Foà and Carbone[18] and Kurloff,[19] working independently, reported their studies on similar cells found in the tissues and peripheral blood of guinea pigs. Describing the inclusion as a nucleus-like figure which took the nuclear stain, Kurloff considered the possibility of an accessory nucleus but had the impression that it was a vacuole filled with material secreted by the cell. It was described as appearing initially as an isolated, punctate granule which gradually enlarged and when about the size of the nucleus, broke through the protoplasm and was discharged from the cell. The work was done on guinea pigs both before and after splenectomy. It is noteworthy that, following uncomplicated splenectomy, a gradually progressive increase of lymphocytes took place until their numbers were double or triple the preoperative level. Foà and Carbone's work was more extensive than that of either Russell or Kurloff and their descriptions of the cells in the spleen and other tissues are admirable. In this original paper published in 1890, they describe the release of intact globules from the parent cells.

Foà and Carbone considered the possibility of the inclusion being a parasite as did numerous others, some even going as far as calling it a "leukocytozoon." Others considered the body to be nuclear material and still others considered it to be a phagocytosed erythrocyte; it is surprising to me to find that some prominent medical authorities still adhere to this latter theory. Of all the possibilities presented, only the secretory "theory" has withstood the tests of experimental observation which now include cytochemical and immunological evaluations.

I and others have fully confirmed the sequence of events described by Kurloff for the development of the secretion as seen on air-dried peripheral blood smears. Smith[20] has published some good photographs of their appearance and presented a good general discussion of their nature and, although I disagree with some of her conclusions, recommend the paper to your attention. Please refer to Figure 2, where two typical mature Foà–Kurloff bodies are pictured. Pearse's work clearly demonstrated that the dark-staining cytoplasmic reticulum represents a precipitated network of ribonucleic acid, a thin layer of which covers the intact bodies and is widespread in the cytoplasm. That which "covers" the bodies undoubtedly represents the ergastoplasm in which the secretion has accumulated. Pearse and others many years before had recognized that the appearance of Foà–Kurloff bodies on an air-dried thin smear was due to crushing and that, in fact, the bodies were "uniformly spherical isotropic" globules. This could be readily observed in fresh, living preparations and in thin smears fixed instantaneously before they could dry and the bodies burst.

Figure 3 has been taken from a 16 mm motion picture made in my laboratory; it shows the appearance of a Foà–Kurloff body in a thick, wet film of fresh guinea pig blood. The nucleus is close to the pointer and the large relatively clear area represents the cytoplasm and globule—the "body" itself. However, in cells with nuclei as large as this one, the bodies will not be seen to occupy the entire cytoplasm but can be found anywhere within it either as single or multiple units. Figure 12 shows a cell vitally stained with brilliant cresyl blue dye. This colorant quickly brings out the inclusion very well but the nucleus is only faintly outlined located close to the pointer.

I, and others long before my birth, have ruptured the cellular membrane under direct vision and seen the release of the "inclusion" bodies. They may come out as intact globules which are transparent, homogeneous and very difficult to see with the ordinary light microscope, or they may be discharged as fluid which immediately mixes with the surrounding plasma. In such instances, the granules, filaments, or rods which can be seen within the vitally stained globule are also "spilled" and their motility is sometimes so striking that they were thought to be spirochetes by some early observers. They may be mitochondria or ergastoplasmic membranes or conceivably both. The "star" shaped clumps may be the so-called secretion granules. Studies are now in progress in this laboratory to clarify their precise nature.

Figure 4 shows a typical Foà–Kurloff body as seen in a tissue section; it is in a pancreatic blood vessel and is shown here because it happens to be a pretty one and it *is* in a blood vessel. Notice the "signet ring" appearance with the nucleus sitting like a

cap on the large globular inclusion; such a cell is "mature" and very close to rupture of the membrane and discharge of its contents. The nucleus will round up with the release of the pressure upon it and cannot then be distinguished from any small lymphocyte; it is not known whether it will normally die or whether it is yet capable of resuming protein synthesis or transforming into another cell type. I would not rule out any of these possible courses based on present information.

Figure 5 shows a large number of Foà–Kurloff bodies in a lymphatic vessel draining the guinea pig thymus in late pregnancy. Various sized globules can be readily seen; if you will look closely at the largest cell in the center of the picture, you will see a basophilic thread connected between the cell membrane and a basophilic mass at the end of the thread. It is difficult to be certain in a preparation such as this but this probably represents the process of clasmatosis—the extrusion of cytoplasm—which I have observed in living cells and which has been beautifully described for plasma cells by Thiéry[3] using phase contrast microscopy.

Figure 7 shows the appearance of the guinea pig thymus in late pregnancy; there is really very little new under the sun as far as ordinary light microscopic observations are concerned. This general appearance had been observed by Fulci[21] over fifty years ago for the guinea pig and the rabbit and similar observations have also been made by others.* The "layer" is composed of typical Foà–Kurloff bodies in all stages of development, many of them within the intrathymic lymphatics. The cells have clearly developed from the lymphoid cells derived from the same epithelium which produces the Hassall's corpuscles. At this stage of pregnancy, the previously "enlarged" thymus is rapidly shrinking in volume and its lymphatics are dilated and engorged with cells. Figure 6 gives an overall view at this stage; the dilated lymphatics can be readily seen at the periphery of the lobules and in the interlobular, fat-filled septa. Figure 5, previously described, is an oil immersion view of the cells in one of the lymphatic vessels seen here. Figures such as this readily explain the observations of Kelsall[22] and others that the regional lymph nodes of the thymus contain more plasma cells than any other lymph nodes.

Figure 8 is a section of guinea pig thymus from late pregnancy, stained with the PAS technique. Only the "inclusions" stain and their distribution is similar to that seen in the specimen pictured in Figure 7. I have shown elsewhere[2] that these cells contain γ-globulin. They are seen in tremendous numbers in the red pulp of the spleen and in relatively small numbers in other tissues of the body. Kurloff's original work indicated that their number in the peripheral blood was not decreased by splenectomy and Heinle and Heydinger[23] noted an absolute increase following splenectomy, indicating a filtering action for the spleen. My own studies extending over twenty years plus the work of Foà and Carbone, Nadel[24] and others support this interpretation.

Electron microscopy of Foà–Kurloff bodies by Weiss[25] and by Bimes, Izard and Guilhem[26, 27] has demonstrated a lamellar ergastoplasm which I interpret to be the "nebenkern" type as pictured by Haguenau.[28] There has not been sufficient work in this area and it is hoped that this will soon be rectified.*

Other Observations

Figure 9 shows a typical mature Russell body plasma cell found, with others, in the thymus of a twenty-five year old pregnant woman who died of an amniotic fluid embolism on her way to the delivery room. Figure 10 shows a typical Russell body plasma cell from the bone marrow of a man who died of multiple myeloma. The bone marrow in the latter case was loaded with these cells; the woman's thymus contained only scattered elements, sometimes occurring in clusters of two or three cells. Only a single section was available for study. Morphologically, these cells are identical and they have been superimposed precisely in transparencies which were exhibited in June 1959.[29] On the basis of extensive earlier work, we can safely infer that the myeloma cell contains "mye-

* For a good recent description, see Ito, T. and Hoshino, T.: Studies on the influence of pregnancy and lactation on the thymus in the mouse, *Z. Zellforsch* 57: 667–678, 1962.

* Since this article was written, several additional references have been found and should be cited here:

[1] Clark, S. L.: Cytological evidences of secretion in the thymus, in Wolstenholme, G.E.W. and Porter, R.: Ciba Foundation Symposium, The Thymus, Experimental and Clinical Studies, Boston, Little, Brown & Company, 1966, pp. 3–30.

[2] Ito, T. and Hoshino, T.: Fine structure of the epithelial reticular cells of the medulla of the thymus in the golden hamster, *Z. Zellforsch* 69:311–318, 1966.

[3] Welsh, R. A.: Kurloff body formation in the guinea pig lymphocyte, *J. Ultrastructure Research* 14:556–570, 1966.

loma" globulin and that the woman's Russell bodies contain gamma globulin, as has been demonstrated for such cells by White,[30] Ortega and Mellors[15] and Mellors and Korngold.[16]

I have previously indicated the timidity of many authors in calling Russell bodies by this name; perhaps it would be better if we all called them mature plasma cells. It is clear that the article on "Intracellular Protein Resembling Russell Bodies in Malignant Lymphomas Associated with Acquired Hemolytic Anemia"[31] refers to mature plasma cells —they can be nothing else. When someone describes a cow in every detail except its tail, it *is* a cow: what else could it be? Similarly, the more recent paper "The Flaming Cell in Multiple Myeloma"[32] attempts to differentiate Russell bodies from other PAS-positive protein inclusions within the cytoplasmic cisternae.

If we are now to move forward and utilize the vast amount of information at hand, we will first have to recognize the relative simplicity of the plasma cell and its secretory activity and stop referring to it by innumerable names which serve only to confuse and complicate the issue. Please understand that I am not deriding the authors of these and other excellent contributions—I am simply calling for some order in nomenclature that will make these studies more meaningful and capable of immediate application.

As I have pointed out in previous communications, there is a tremendous store of untapped knowledge in our books and journals; a clarification of the nature and physiology of the plasma cell should now be possible and the potential rewards in terms of understanding and treating most of our "diseases of mystery" are truly almost beyond the imagination. For, certainly, the lowest common denominator for many diseases has been found to be the lymphocyte or plasma cell. Beard[33] knew, prior to 1900, that the thymus is producing and distributing leukocytes before there is any functional spleen, lymph nodes or bone marrow. Shaffer[34] recognized in 1909 that the thymus of moles produces large numbers of plasma cells and he verbally described the picture shown in my Figure 7. He noted, in addition, that such plasma cells were to be found also in the thymus of the mouse, the white rat, the dog, and in man. And, like Kelsall, he noted accumulations of plasma cells in the parathymic lymph nodes. How different medicine might be today if all the workers on the thymus and plasma cells had gotten together about 1915 to put things together; they had a fine research program but their "development" activities were being neglected.

Russell Bodies, Foà–Kurloff Bodies and Plasma Cells

So that there is no way of mistaking my sometimes devious remarks, I want to state clearly and emphatically that the total body of evidence available today says that Russell bodies and Foà–Kurloff bodies are identical in origin and function and that they simply represent late secretory stages of plasma cells. At the same time, I recognize that under appropriate circumstances the secretion may be released very rapidly and that "bodies," as such, may not persist and enlarge.

The thymic production and export of plasma cells is so clear and the appearance so unique that, coupled with the other evidence presented here, the well known effects of thymectomy and the demonstrations by Good[35] and others of the relationship of thymic tumors to agammaglobulinemia, I am convinced that the thymus is the sole normal producer of plasma cells. This does not exclude the possibility of some peripheral reproduction of these cells but if they and the thymus are both destroyed completely, regeneration can not occur. Many of the experiments of Nature bear upon this point but I shall not discuss these at this time.

We should certainly adopt a common name for these and other identical cells, to be applicable in all species which form them. Such recognition would be extremely helpful in any efforts to "liberate" many worthwhile contributions now lying dormant in the literature.

Why Hasn't the Cellular Production of the Thymus Been Widely Recognized Earlier?

There are three major reasons why this role of the thymus has not been widely recognized or understood:

(1) The retention and perpetuation, even today, of old dogmata limiting its function to youth and childhood,

(2) Carry-over of the rigid interpretation of the germ layer theory to the effect that epithelium cannot produce leukocytes,

(3) Misinterpretation of the meaning of thymic size based on 1 and 2.

The continued persistence of these errors in many places offers grim confirmation of the fact that once an error is introduced into medicine and widely accepted, it may require a Herculean effort to get it out. As Richter[36] so aptly pointed out, ". . . ein Irrtum ist Schwerer zu bekämpfen als hundert Wahrheiten"!

No single idea has done more to stifle research on the thymus than that limiting its activity to early life. The effect is still reverberating, as unwarranted conclusions are drawn from the results of neonatal "thymectomy" as they relate to immunologic defects or the lack of them. Certainly, nothing that has been done to date justifies the conclusion that thymic function is limited to the fetal or neonatal period. Seasonal changes in the thymus of adult animals, hibernating and non-hibernating, have been described repeatedly as have pregnancy changes. I[37] have described, in part, the changes that take place during the sixteen day estrus cycle of the guinea pig. Selye, beginning in 1936, has described the predictable responses of the thymus to a multitude of stressors. Dozens of authors have described the large thymus as it often appears in adults who have died suddenly while in good health. Unfortunately, most of these writers considered the presence of a large thymus abnormal, in accordance with their own education. Executed criminals with large thymuses, suicides with large thymuses, soldiers with large thymuses—whatever the occupation or reason for death might have been, the "persistent" thymus was implicated as a culprit! The observations were forced to fit into a preconceived pattern.

When I needed some large thymuses from adult human beings for use in an AMA exhibit in 1959, Dr. Leander Van Hecke, Medical Examiner of Milwaukee County, had them for me in a very short time, all obtained from cases of sudden death. All he had to do was look for them. Also, through the kind assistance of Dr. Frank Glassy, then at the Milwaukee County General Hospital, I was personally able to examine the thymus tissue from individuals up to the age of ninety-one years. They all appear "active" when compared with material of known history from guinea pigs. If you consider the age of ninety-one years to come within the purview of infancy and *first* childhood, I shall not persist in my arguments! In fact, rather than belabor the point, I shall refer you to Hammar,[38] Crotti[39] and my 1950 paper;[40] there are innumerable references to back up the point that the thymus is a functional organ throughout life.

The second major point of error concerned the supposed inability of epithelium to produce lymphoid tissue. Today, there is no question about it but it really didn't take tissue culture and isotopes to prove it. A good, unbiased observer with a microscope did it long ago. Who could express it better than Beard[33] who said: "In his work on the thymus Stieda asks '. . . how can adenoid tissue arise from an epithelium?' This is a matter for observation, and it may not simply be denied out of existence by a mark of interrogation! The difficulty may have been a real one in 1881, when there were no observations whatever—even after the publication of Stieda's own researches—beyond Kölliker's discredited but correct ones, concerning the origin of lymphoid cells . . . now there is no longer any difficulty about the matter, when dozens of drawings and thousands of preparations can be produced to show it. Where Nature places no obstacle in the way of carrying out a process, it is not for man to invent one! The fact is that in Nature, as Kölliker first stated in 1879, adenoid tissue does arise from epithelial cells." Amen.

The third major point of error has been the most difficult to overcome and it is based very largely on points 1 and 2. My own views on this subject have so upset some pathologists that I have been placed in danger of bodily harm—and I am not exaggerating! Two exhibits, in 1955[41] and 1959, gave me ample opportunity to discuss my views with many physicians and I know whereof I speak. For me to claim and defend the notion that the small, oft'times nearly invisible thymus is a very active organ was nearly sufficient to have me committed to you-know-where. Some sessions involved great bodily proximity and one didn't need extrasensory perception to detect that there was some emotional involvement. Such observations are not really irrelevant here for history should record that it was the same sort of dogmatic, no-think attitude that led to the "banishment" of the thymus in the 1930s and led to its becoming a subject which was

not discussed openly among knowledgeable practitioners of medicine. I thought I was living in the dark ages when one of the leading hospitals in the country, less than fifteen years ago after extended thought on the subject over a period of months, granted me permission to look at their pathology collection of thymus slides taken from persons who died of leukemia. The hooker was that I was not permitted to tell anyone that they let me do it! To tie the thymus in with leukemia in human beings was a heretical thought and too risky for then-modern times. It is sad but it is true. These things you should know for only then will you fully understand why it has taken so long to arrive where we are today.

In Selye's alarm reaction, the adrenals hypertrophy and the thymus shrinks; does it "atrophy?" In the estrus cycle of guinea pigs, the thymus dumps its cells in huge numbers about the time of ovulation and gets smaller; is this "atrophy?" In pregnancy in many species, the thymus is as large as it ever gets during most of the period of gestation but dumps its cells in large numbers and nearly disappears grossly as term approaches; is this "atrophy?" If an organ fluctuates greatly in its bulk, if it decreases to near invisibility and then regains its former size, should we consider the small organ "atrophic?" It would be perfectly all right to do so if we so defined the term. However, the terms "atrophy" and "involution" are generally used to imply something more permanent. "Accidental involution" of the thymus was taken to mean virtual cessation of thymic function, whatever it may be, prior to the time of normal "age involution", a supposed diminution or cessation of function around the time of puberty. Hammar preached continually on the incorrectness of these interpretations but his views did not prevail. The fact is that the large thymus with a well-defined cortex and medulla is *relatively* inactive; the enlarging thymus with numerous mitotic figures and no differentiation between cortex and medulla is very active in regenerating its bulk but relatively inactive in pouring cells into the circulation; the small thymus, the one that is difficult to see, is losing its cells nearly as fast as it makes them—it is the *most* active on a continuing basis.

Once one understands the basic physiology of the thymus, things fall into place and the fog begins to lift. Epithelial cells do produce lymphocytes, lymphocytes do turn into other cell forms, cells do leave the thymus in large numbers, the thymus does persist throughout life, and the small thymus *is* functioning!

If these facts had been understood and applied, we would not be seeing the great number of papers in our literature stating that the thymus does not normally produce a significant number of plasma cells, that it is not a significant producer of antibody, and that it does not participate significantly in the leukemic process in man. There even has been the suggestion that a thymic barrier to antigen exists because direct inoculation of an antigen into the thymus stimulates noticeable local antibody production while this does not appear to be true to a significant degree otherwise, when regional lymph nodes and the spleen may be virtually loaded with γ-globulin.

Because it is so important that you understand this concept, let me make a simple comparison. Suppose that the building next door to you is on fire. You sound the alarm, the fire trucks come, the firemen get busily at work, and the local activity is intense. Some firemen are injured and are quickly transferred to the Nodal receiving station where the real seriousness of the situation is at once perceived. Word goes out that reinforcements are needed and the Home Fire Company sends out most of its remaining men and equipment and calls for recruits, knowing that there will be little time to train or retain them. All the men and equipment cannot be accommodated at the scene of the fire so many stand in reserve on Spleen Street while others patrol the entire area. Meanwhile, a visiting Martian inspection team, anxious to know how we do things here and noting the tremendous activity going on, investigates the Fire House, for previous hunches had told them this was the place to look for basic information. Seeing only an occasional recruit who pauses but a moment before he puts on his red jacket and leaves, they conclude that the Fire House is probably an unimportant part of firefighting and decide to go where the action is.

The firemen themselves feel differently about it. They consider the Fire House to be their home. They, as firemen, are "born" in it, they grow in it, are nurtured by it, and receive their "instructions" there. After a serious fire, few get to return for any extended period of time, but all agree that if it weren't for the Fire House, they wouldn't

be around in the first place, for that is where all firemen come from. This may seem childish but if this type of thinking had been applied to the thymus fifty years ago, medicine today would be far different from what it is.

The Thymus, Its Cells and Disease

My 1950 paper[10] summarized the evidence favoring the thymic origin of leukemia in man and animals, and I refer you to it at this time. The evidence was excellent then that this disease arises in the thymus; today, it is overwhelming. While the laboratory experiments have been done chiefly in rodents, "experiments of Nature" have amply shown the identity of the process in the human species. The mental block—the "veil," if you will—has been the "atrophic" thymus at autopsy—the tissue so depleted that it presents a paradox! A presumably lymphatic structure which is *not* participating in the generalized engorgement by leukemic cells can scarcely be taken seriously in the human disease, so they say. I plan to bring my old paper up to date and will discuss the subject more fully at that time; the conclusion will be, as before, that leukemia, regardless of type, is a thymic disease.

A common denominator of many superficially unrelated diseases is a disturbance in the type or amount of plasma globulin present. Diseases may be grouped as being among the hyperglobulinemias, for example, or the hypoglobulinemias They may be characterized further by defining the specific globulin involved. For example, hypo*gamma*-globulinemia, *macro*globulinemia, *cryo*globulinemia, *pyro*globulinemia, and so on. This is well recognized today and there is no need to belabor the point. Similarly, there are hundreds of original articles and many reviews on the subject of the precise cellular origin of the plasma globulins. The bulk of the work has been on the cellular source of gamma globulin, but it is apparent that other fractions are involved as well and that the gamma globulins are a heterogeneous group of proteins.

The principal cell of origin of the immunoglobulins is now universally recognized to be the plasma cell, and participation in synthesis by some other fixed cells of the extrathymic reticulo-endothelial system is considered by many, but not by me, to be a probability. There have been numerous publications on the central role of the plasma cell in superficially unrelated diseases, and I featured this concept in the 1959 AMA exhibit. There has been a very recent publication on the theme and I shall refer you to it for a very nice summary of much of the existing material.[42]

If I may quote myself,[43] "There is today abundant evidence that hypersensitivity to foreign products as well as to the internally liberated products of one's own body may trigger severely disabling or lethal mechanisms in the human being, as well as in the experimental animal. It is likely that the phenomena and lesions of rheumatic fever, rheumatoid arthritis, lupus erythematosus, myasthenia gravis, multiple sclerosis, and numerous other conditions ameliorated by cortisone and related substances, have their pathogenesis in an exaggerated immune mechanism which works to the detriment of the host. A process which starts out as a defense mechanism may end up by crippling or destroying the victim of an otherwise relatively innocuous disease." The globulins are at the center, the plasma cell is their source, and the thymus is the supplier of the plasma cells.

Lupus erythematosus should come in for special treatment in view of the widespread interest in the LE cell. In my opinion, most naturally occurring mononuclear "LE" cells are no more a special type of cell than are Russell bodies in "myeloma" cells. Both are plasma cells still retaining the accumulated *secretion*, not phagocytosed material. I do not contend that the "LE" cell, so-called, may not contain nuclear material surrounded by the "LE factor." This seems obviously to be the case in systems set up purposely to have this happen. Bear in mind that most such "systems" have been set up on the basis of the preconceived assumption that the LE factor is an anti-nuclear factor, that it somehow enters into a nucleus and causes its degradation, homogenization and subsequent phagocytosis. In fact, such experiments prove nothing of the sort.

Why not call the LE factor a pro-nuclear factor instead of anti-nuclear? There is evidence that the globulin has an affinity for degenerating nuclei—that they become coated with globulin. The same globulin may also coat other structures than nuclei and is obviously deposited widely in the body as has been shown by numerous investigators. Why not call it an anti-spleen, anti-kidney, anti-many organ-factor?

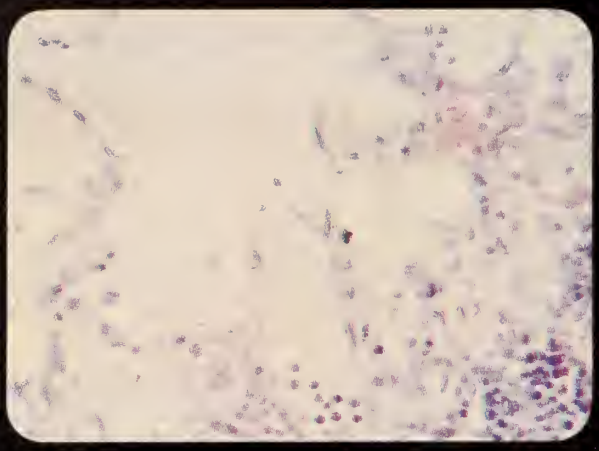

Fig. 1—Detail of lymphatic vessel carrying cells out of the thymus. Note the one-way valves.

Fig. 2—Foà–Kurloff bodies, air-dried smear, Wright's stain.

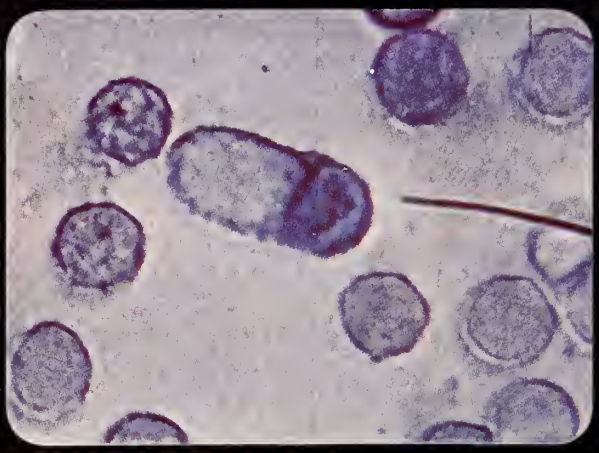

Fig. 3—Foà–Kurloff body as seen in a wet preparation of peripheral blood. (From a 16 mm motion picture frame).

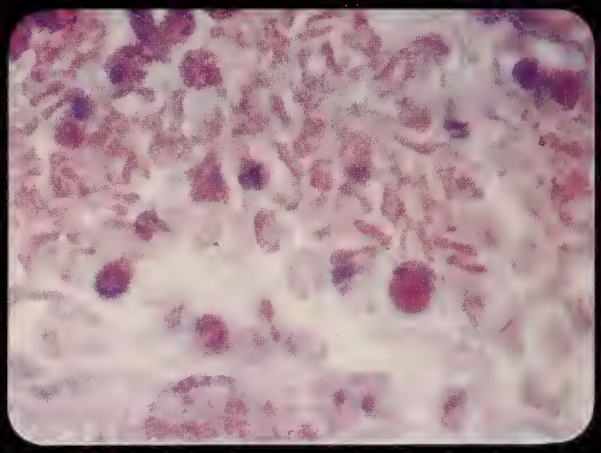

Fig. 4—Foà–Kurloff body in a pancreatic blood vessel; hematoxylin-eosin azure stain.

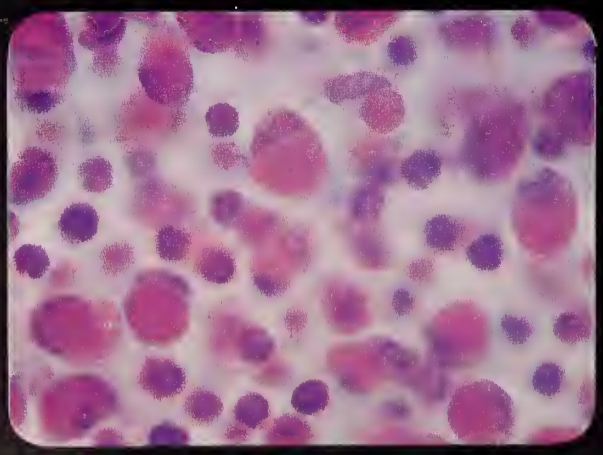

Fig. 5—Foà–Kurloff bodies in a lymphatic vessel; see Figure 6 for low-power view. (HE&A stain)

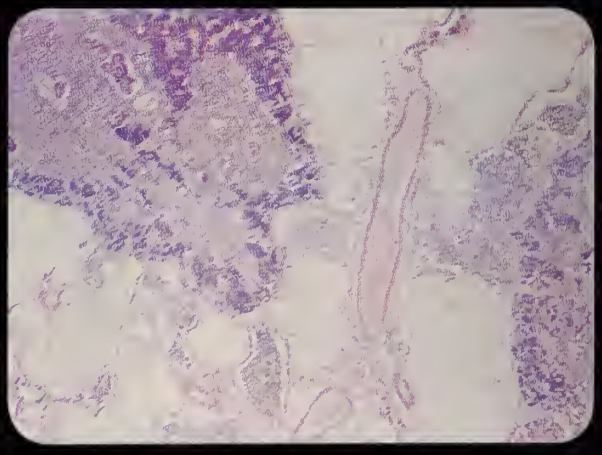

Fig. 6—Low magnification view to show appearance of guinea pig thymus in late pregnancy. The dilated vessels filled with cells are lymphatics; see Figure 5 for details of their cellular content. (HE&A stain)

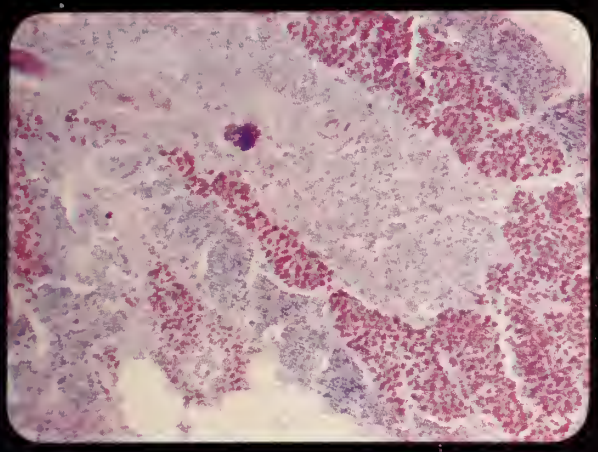

Fig. 7—Single lobule of thymus, guinea pig, late pregnancy. Note the "layer" of Foà–Kurloff bodies. (HE&A stain)

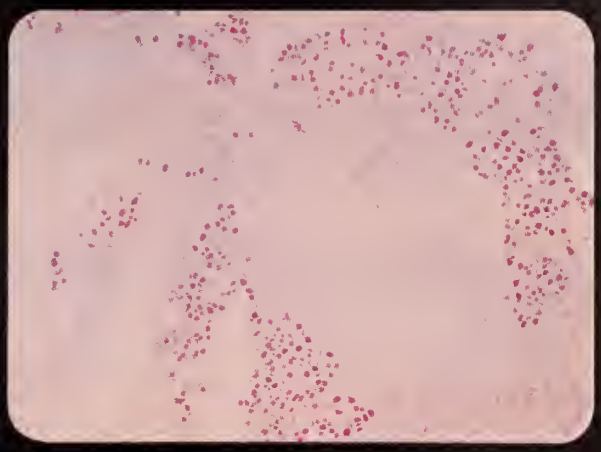

Fig. 8—PAS stain of single lobule of thymus, late pregnancy, guinea pig. Only the inclusions stain.

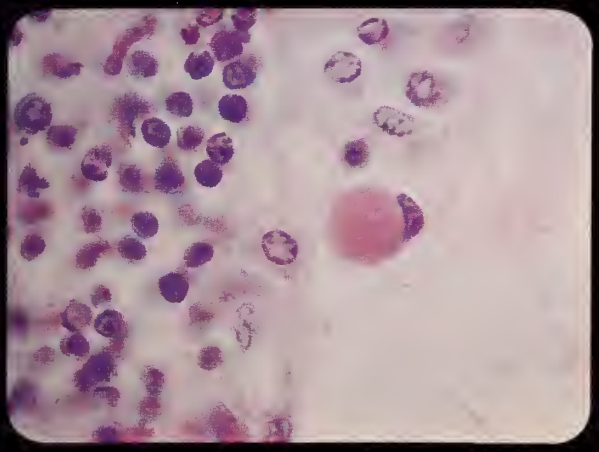

Fig. 9—Russell body plasma cell from a twenty-five year old pregnant woman's thymus.

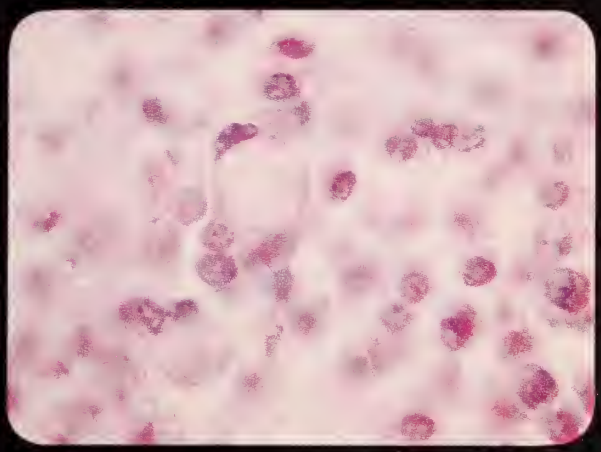

Fig. 10—Russell body plasma cell, bone marrow, multiple myeloma, human.

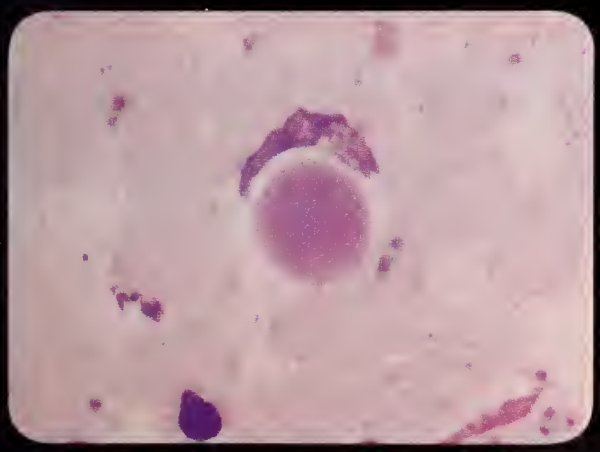

Fig. 11—Mononuclear LE cell; bone marrow, human.

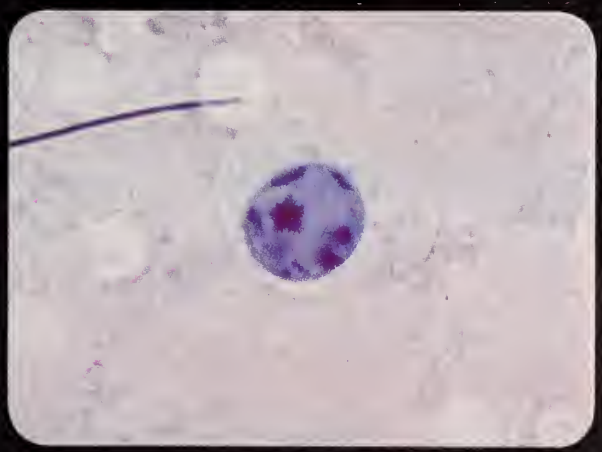

Fig. 12—Foà–Kurloff body vitally stained with brilliant cresyl blue; the inclusion is stained well but the nucleus is only faintly outlined.

I have carefully reviewed Morton's[44] thesis and the original paper by Hargraves, Richmond, and Morton[7] and do believe that they fell into the trap mentioned by Russell and other investigators around 1890. You will recall that a nuclear origin for the inclusion "body" was considered and ruled out by some but not by all and that, regardless of the precise nature of the body, the unusual appearance stimulated a great deal of new research. The original evidence of Hargraves et al is not at all impressive that the inclusion is nuclear in origin. But once one buys the idea that it is, he is "sunk." If you will go back to the early literature on the LE cell, you will find many discrepancies in observations which did not tally at all with known means of identifying nuclear material; in spite of this, the differences were explained without giving up the basic thesis. Aside from some degree of Feulgen staining, the inclusion in the natural disease state does not possess chemical characteristics of nuclear material but does contain gamma globulin—the "LE factor." However, in support of the basic thesis, some authors have ascribed to the factor a potency so great that it is said to be capable of completely destroying any possibility of identifying a nuclear origin chemically. This, I do not believe. In fact, the only way that one can get truly identifiable nuclear material is to do it with an experimental set-up wherein one assures the end result by using degenerating nuclei which can be coated by the "factor" in the patient's blood and then phagocytosed. Even in such systems, "nuclei" are found sans nuclear characteristics in phagocytosing cells. Recall, if you will, that bombardment of the patient's cells increases the yield of LE "factor" and positive LE cell formation. Traumatize the plasma cells—beat them with glass beads, squeeze them with blood clots, milk them out! Rupture the cellular membranes, release the fluid content, release the intact "bodies" into the plasma or serum, subject the resultant fluid to foreign cells, degenerating forms and live phagocytes, and watch the LE cells develop! Intact bodies released by plasma cells have been observed by Thiery[45] in the process of phagocytosis; he was observing the development of a typical LE cell but did not recognize it as such. Burnett,[46] as far back as 1904, observed phagocytosis of released Foà–Kurloff inclusions but attached no special significance to it.

Figure 11 illustrates a typical mononuclear LE cell from the bone marrow of a patient who died of lupus erythematosus. Figure 12 shows a Foà–Kurloff body vitally stained with brilliant cresyl blue to bring out the inclusion. The nucleus is only faintly outlined. These photographs can be superimposed precisely. In the light of these observations, it is interesting to note the findings in a recent review[47] of the microscopic appearance of the thymus in lupus erythematosus. The most consistent and striking feature in each case description was the appearance of plasma cells and Russell bodies; the size of the thymus varied considerably. Before leaving the subject, I think I should mention that the "hematoxylin bodies" of many authors appear quite obviously to be the extruded globules from plasma cells.

My views on the development of LE cells were first conceived in 1950 and presented publicly in 1959;[29] other reports may be found in the 1961[48] and 1963 presentations.[43] I plan to write a separate article developing these concepts more completely.

The development of amyloidosis has been traced repeatedly to the presence of plasma cells and their deposition of globulin in the tissues. To fully discuss the subject would double the length of this paper but the conclusion would be that amyloid, whether one calls it primary, secondary, or by some other name, is not produced without plasma cells.

I have mentioned multiple myeloma in connection with Figure 10. The individual cells vary considerably in appearance in this disease but the myeloma cell is a plasma cell and, in my way of thinking, myeloma is a thymic disease. I would not quarrel with those who point out solitary myeloma lesions in the periphery; it is the *origin* of the wayward cell of which I speak.

The subject of cancer in general will have to be dealt with *in extenso* in a separate communication. The thymus is involved not only as a supplier of nutritive materials but is quite obviously concerned from the standpoints of immunity and of normal tissue growth and differentiation. There is a perfectly fascinating story to tell about the homologous prothoracic glands in metamorphosing insects but I must forego the temptation to do it here.

The blood of some patients with multiple myeloma has been found to contain an abnormal amount of a protein-lipid-carbohy-

drate complex presumed by the investigators to have originated in the myeloma cell.[49] This is certainly a logical conclusion, particularly in view of the cytochemical studies of Russell bodies mentioned earlier. Findings such as this throw the thymus into the atherosclerosis arena as evidence increases for participation in the process by such plasma components.

Wire-loop lesions in the glomeruli and other evidences of globulin deposition in the kidneys or elsewhere should all be considered evidences of plasma cell activity as should plasma glycoprotein variations in normal and toxemic pregnancies. The phenomena of toxemia as well as the precipitation and maintenance of labor itself may well be related to the plasma cells and to the thymus. There is a considerable amount of evidence that this is so.

Abnormalities of the blood clotting mechanism have been noted frequently in multiple myeloma and in other forms of lymphoma and leukemia. These phenomena, too, may very well be related directly to the thymus. While this topic is similarly deserving of a separate paper, consider briefly the following points:

(1) The basic cellular characteristics of the "mast" cell and the "plasma cell" are the same.

(2) Both cells show basophilic secretory granules early in development, the mast cell form being designated as such because of this appearance.

(3) Both cell forms have been observed to discharge their "granules;" in both cases, the "granules" are PAS-positive as are platelets,[50] which, in my opinion, they could be.

(4) If the mast cell granules became larger and became eosinophilic, the same cell would then be called a Russell body plasma cell; if the granules became eosinophilic and did not enlarge, the cell would be designated as an eosinophil.

(5) "Mast cells," "plasma cells," and "eosinophils" are all normal constituents of the thymus but vary greatly in number at different times.

(6) Dense accumulations of PAS-positive mast cells have been reported[51] in the thymus of pregnant rats; it was also noted, on the basis of 200 tissue cultures, that "the thymus seems therefore to be the only organ capable of producing full value mast cells while the spleen and the lymph nodes are practically incapable of that function. The liver seems to synthesize heparin, but this finds no expression in the migration of mobile cells; the cells are storing this material . . . ."[52]

(7) The "mast cells" described above are identical in description and location and are found in the same physiologic states as the young plasma cell forms seen in my thymus material.

(8) The thymuses of golden hamsters *(Mesocricetus auratus)* have cells identical to those in my guinea pig preparations; they have the same tissue distribution and are PAS-positive.[53] Studies with the same species have shown that on the 14th day of the 16-day gestation period, the platelet count rises significantly as does the susceptibility of the animal to the development of the generalized Schwartzman reaction with extensive intravascular coagulation.[54]

To my knowledge, there has been no work designed specially to clarify the role of the thymus in the coagulation mechanism; the facts outlined here suggest that such would be in order.

Complete Thymectomy

There is considerable reason to believe that a complete surgical thymectomy has never been accomplished in any species. I shall admit at once that I have never achieved it in guinea pigs or in the numerous mice on which I operated in 1951 and 1952 in a leukemia study. Operating with the use of a fine binocular microscope and being thoroughly familiar with the anatomy was insufficient to discover all the thymus present. The location of the remainder was facilitated by the use of Carnoy's solution but, unfortunately, such fixatives are not compatible with continued existence for the animal.[55]

The thymus arises in the neck, embryologically, and in some species which include man, descends in part into the chest. There are invariably cervical segments present in man. In every animal I have examined, whether it be cat, dog, rabbit, mouse, rat, guinea pig, or calf, I have always found thymic tissues unrelated spatially to the main mass.

Getting out *most* of the thymus is easy; the removal of all of it is not. Before accepting the *possibility* of complete thymectomy in any species, I would like to see healthy, castrated control animals examined by the Carnoy technique to determine precisely the normal thymic distribution. Even here, it may be possible to miss tissue associated closely with the parathyroids or thyroid gland.

In my opinion, the results achieved to date by thymectomy experiments have been observed in incompletely thymectomized animals; it would be extremely difficult to detect thymic "remnants" later in such animals as, most assuredly, they would have little opportunity to "rest" and enlarge.

Discussion and Conclusions

I find it very difficult to agree with Carlson's[56] conclusion that ". . . it seems quite clear that for the processes of senescence that make their clear appearance in man from the age of forty to fifty on, the thymus gland is not even one of the minor prophets in Israel." To me, it seems more likely that the thymus sits in Moses' seat! The thymus has been neglected, abused, and misinterpreted; we stand today on the threshold of new understanding and, hopefully, successfully treating and preventing many of the mysterious scourges of mankind—and his lower brethren, too.

The thymus is obviously tied in close relationship to many diseases and complexes of diseases involving the thymic cells and their products. There is talk today of a thymic hormone being produced by the PAS-positive cells in the thymus; this may well be so and it is for this and other reasons that I would prefer not to call the plasma cell an "immunocyte" and thus tend to limit its potential in our thinking. Lest I forget to mention it, I thought I was the first to suggest that the PAS cells secrete a thymic hormone when I did this in the 1955 exhibit; however, as I have since learned, such an hypothesis had been made many years before on the basis of equally good presumptive evidence.

Without going into details, the leukocytic gamma globulin inclusions in rheumatoid arthritis are probably basically the same as those occurring in other dysglobulinemias and are, as detailed in the paper, plasma cell products.

The old concepts of "collagen diseases"[57] have given way to the "plasma cell dyscrasias"[58] and we are now at the stage of considering the thymus as the hub of a vast complex of diseases, yet necessary for health and life. Past efforts to stimulate or depress it—to treat *its* malfunction—have been aimed, instead, at the peripheral disease. Along these lines, I shall never forget a fascinating lecture by Harry Beckman based on Sir Francis Bacon's remarks to the effect that no man can rightly study the nature of anything *in the thing itself*. We have made little progress in leukemia, in multiple myeloma, in the multitude of allergies, hypersensitivities, and disorders of globulin by studying the lesion—the "thing" itself. We must go back to the thymus for the answers. We must first know what questions to ask. And may I humbly suggest that many of the "answers" may already be available? Please recognize that today's interest in the thymus is a re-awakened interest and that an enormous literature on the thymus already exists, as do many ancillary studies which can be re-interpreted in the light of present day knowledge. Much needless work can be avoided if we will avail ourselves of the legacy held for us in our libraries.

As I began with a quote from Selye,[59] so shall I close, for none of our contemporaries have come closer to "the making of Nature:"

> *"The physicochemical basis of the curious terminal loss of acquired adaptation is still quite obscure. Exhaustion cannot be fully compensated, either by changes in the caloric intake or by any known hormonal substitution therapy. The term* adaptation energy *has been suggested to designate the adaptability that is gradually consumed during exposure, but despite much research we have learned nothing about the nature of this 'energy.'*
>
> *"Many of the changes characteristic of the stage of exhaustion are strikingly similar to those of senility. It is tempting to view the general adaptation syndrome as a kind of accelerated aging. It appears as though, because of the greater intensity of stress, the three major periods of life—infancy (in which adaptation has not yet been acquired), adulthood (in which adaptation has been acquired to the usual stresses of life), and senility (in which the acquired adaptation is lost again)—are here telescoped into a short space of time."*

Might this "adaptation energy" be the thymus?

SUMMARY

The author considers Foà–Kurloff bodies and Russell bodies to be identical constituents of plasma cells and, while recognizing that peripheral replication of cells is possible, considers the thymus to be the original source of plasma cells throughout life. As such, he relates diverse disorders of globulin production and deposition to the thymus. Such conditions as multiple myeloma, leukemia, and other malignancies are considered either thymogenic or related to the thymus via the products of its cells, either as trephones, growth regulators, or both. Additional communications will follow to furnish additional supporting detail as indicated in the paper.

The Parkway at Fairmont (19101).

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This work was begun in The Department of Anatomy at The University of Chicago and was carried forward in the Departments of Physiology, Pharmacology, and Pathology at Marquette University School of Medicine, Milwaukee, and in the laboratory of The Fidelity Mutual Life Insurance Company, Philadelphia.

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UW PEDIATRICIAN DISCOVERS CLUE TO CYSTIC FIBROSIS

A pediatrician at the University of Wisconsin Medical School, Madison, has uncovered a significant clue in the long search for the cause of cystic fibrosis.

Dr. John A. Mangos, an assistant professor of pediatrics and a staff member of the UW Medical School's Cystic Fibrosis Center, discovered that sweat and saliva from children with cystic fibrosis cause rats to excrete saliva which has a high sodium chloride content.

He reported his finding at the recent annual meeting of the American Society for Pediatric Research.

Doctor Mangos' evidently simple discovery has several important implications for researchers on the track of the basic molecular defect in the body which causes cystic fibrosis.

In the first place, his research marks the first time any relationship between the disease in humans and in animals has been illustrated—a valuable discovery, since future C/F research can now make extensive use of rats.

But the most significant implication is based on the known fact that children with cystic fibrosis excrete abnormally high amounts of salt in their sweat and saliva. This feature is one of the important ways of diagnosing the disease.

Doctor Mangos reasoned that if there is some factor in the sweat and saliva of C/F children which causes rats to excrete very salty saliva, then that same factor may be responsible for the high salt content of the children's own sweat and saliva. And that factor, once it is isolated, may go a long way toward pinning down the molecular defect which causes the disease.

Although Doctor Mangos' study has "no direct therapeutic significance," as he comments, it could have a crucial secondary effect on therapy. "Once the biochemical defect is known, the approach to patient therapy will be constructed on the basis of that knowledge," Doctor Mangos emphasized.

He got his first hint that the rat's parotid gland might have some connection with cystic fibrosis while testing the effects of salt transport inhibitors on the gland two years ago at the Free University of Berlin. "I felt," he says, "that some of the changes in the salinity of rat parotid saliva were similar to changes known to occur in the sweat and saliva of cystic fibrosis patients."

Doctor Mangos' project—in which he was assisted by Mrs. Nona R. McSherry—was conducted as part of the Wisconsin Cystic Fibrosis Center program in C/F care, research and teaching. The Center is one of 35 similar institutions in the U. S. supported by the National Cystic Fibrosis Research Foundation, a private organization.

The Wisconsin center also receives support from the National Institute of Arthritis and Metabolic Diseases and the state of Wisconsin's Bureau for Handicapped Children.

* * *

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The Aspirin Tolerance Test

By ARMAND J. QUICK, Ph.D., M.D.
Milwaukee, Wisconsin

■ THE OBSERVATION that a relatively small dose of acetylsalicylic acid increases the bleeding time even in many normal subjects[1] has been like the proverbial stone that killed two birds. It has furnished the basis of a new diagnostic procedure of hemostasis, the aspirin tolerance test, and it has supplied new information on the pharmacologic action of the salicylates which will aid in employing these drugs more critically. All this has been accomplished by a simple approach using the unmodified bleeding time test described by Duke in 1910.* Since the new material is of immediate applicability for nearly all physicians, it will be presented in an informal manner, rather than as a scientific treatise. No apology is made for keeping the presentation at an elementary level. Few physicians are able to keep abreast with the current complex developments in hemostasis, but every practitioner, regardless of his specialty, should know the basic principles underlying the body's protection against undue loss of blood and how this mechanism is impaired in various pathologic conditions that are usually designated as the hemorrhagic diseases.

The Clotting and Bleeding Times*

These two procedures are the oldest and at one time were the only simple available hemostatic tests. Both have been justifiably abandoned as routine tests in many hospitals. The clotting time is subject to technical errors such as a poor venipuncture which can easily result in a false normal but, more serious, the test is normal in many important hemorrhagic diseases. The clotting time is prolonged only when a particular clotting factor is deficient or when an anticoagulant such as heparin is present in the blood. Since such abnormalities are measured more sensitively and definitively by the one-stage prothrombin time and the prothrombin consumption time, these tests have largely supplanted the clotting time.

The bleeding time, in contrast to the clotting time, has remained an indispensable test but its importance is underestimated. This is due in part to faulty technique but even more cogent is the failure to understand the basic physiologic principles underlying the test. According to the procedure devised by Duke, a cut is made in the lobe of the ear and the issuing blood drops blotted every 30 seconds. Normally, the droplets soon decrease in size and bleeding ceases entirely in 3 to 4 minutes. Apparently, a mechanism comes into play that brings about a contraction of the severed blood vessels. Since the vessels in the lobe of the ear are small, because the need for blood in this tissue is minimal, what is actually tested is the hemostasis of the microcirculation. Significantly, the bleeding time is normal in hemophilia and other diseases with a coagulation defect, thus showing that hemostasis of the microcirculation is independent of the coagulation mechanism.

In his original study, Duke observed that the bleeding time was prolonged in severe thrombocytopenia and soon thereafter Minot and Lee and, independently, von Willebrand discovered a hemorrhagic disorder in which the bleeding time was prolonged, despite a normal platelet count, good clot retraction, and a normal clotting time. This condition, which, for the sake of clarity and to honor its discoverers may be called the Minot–von Willebrand syndrome, depends primarily on the bleeding time for its diagnosis. Unfortunately, the mild cases belonging to this syndrome have a normal bleeding time and since such patients often have a subclinical bleeding history, their condition is not diagnosed correctly. Thus, it is understandable why this disorder which is far more common than the better known hemorrhagic diseases such as hemophilia has been regarded with indifference until recently.

The Aspirin Tolerance Test

The observation that many normal subjects have a prolonged bleeding time two

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Doctor Quick is Professor Emeritus of Biochemistry, Marquette University School of Medicine.

This work was supported by a grant from the National Heart Institute, National Institutes of Health, U.S. Public Health Service, Bethesda, Md.

* The methods employed are described in detail in my monograph on *Hemorrhagic Diseases and Thrombosis.*[2] The early history of the subject can also be found therein.

hours after ingesting two to four 5-grain tablets of aspirin led to the development of the test. A dose of 0.65 gm (10 grains) was selected as the adult tolerance quantity since it rarely prolongs the bleeding time beyond four minutes in normals. The bleeding time is done by the unmodified but rigidly standardized Duke's procedure. It is imperative that the patient not take any medicine containing acetylsalicylic acid three days prior to the test.

The physiologic action of acetylsalicylic acid has not been unequivocally established but as a simple and practical explanation the following theory has been proposed. The control of the tonus of the vascular system is through the autonomic nervous system of which epinephrine and acetylcholine are the major hormones—one being the pressor, and the other the dilator. After injury, cholinesterase is activated, whereupon acetylcholine is hydrolyzed allowing the action of epinephrine to dominate, and thereby bringing about constriction and cessation of bleeding. When acetylsalicylic acid is present, it acts as a competitor for cholinesterase because it has a structural similarity to acetylcholine. Both contain the acetyl linkage. As a result, the acetylcholine is not inactivated by hydrolysis because the esterase is tied up with aspirin. It therefore continues its vasodilatation effect, thus preventing the contraction which is the initial step in hemostasis. In support of this theory is the observation that sodium salicylate which lacks the acetyl linkage does not prolong the bleeding time. Whether this hypothesis adequately explains the action of acetylsalicylic acid can only be established by pharmacologic research. The explanation is offered primarily as a working guide. It does not affect the practical application of the aspirin tolerance test.

The Minot–Von Willebrand Syndrome

This usually mild bleeding disorder is widely distributed, as is to be expected, since it is inherited as a non sex-linked autosomal dominant. Yet, it was not recognized as a distinct clinical entity until less than four decades ago. Even today, many subjects with the defect pass through life without ever being aware of their abnormality. The situation is somewhat analogous to the hemolytic jaundice induced by primaquine. The hereditary deficiency of the enzyme, glucose-6-phosphate dehydrogenase, subjects these seemingly normal individuals to severe hemolytic jaundice on taking the anti-malarial drug, primaquine. In the Minot–von Willebrand syndrome, seemingly normal individuals are sensitive to acetylsalicylic acid and it is this sensitivity which is measurable by the bleeding time as carried out with the aspirin test.

Diagnosis of the Minot–von Willebrand syndrome must be made on the triad: history, physical examination, and laboratory findings. Epistaxis and easy bruising especially during childhood are common and may be especially significant diagnostically if familial and present in several generations. The physical examination is usually negative except for ecchymoses but even these may be absent. The routine laboratory tests for hemostasis are normal except for the bleeding time and the tourniquet test. The key test is the bleeding time but in mild cases this too is normal. The tourniquet test may be normal but in an occasional case, strongly positive; the interpretation of this test is difficult and uncertain.

The paucity of means to establish a diagnosis of the Minot–von Willebrand syndrome has made the aspirin tolerance test exceedingly valuable. By means of this test, it is possible to study families and find various affected members who are unaware of their abnormality, as illustrated by the following:

Case Reports

Case 1. A white woman, age 45, recalled that she was anemic during childhood. At age 13 she had mononucleosis which was complicated by severe epistaxis. Since then she has had no other nosebleeds. Tendency to bruise was not marked during childhood but has steadily increased. She bleeds easily from her gums. She had severe bleeding following extraction of some teeth but not from others. A tonsillectomy and appendectomy were not complicated by postoperative bleeding. Menstruation was always heavy. Her first pregnancy ended in a miscarriage. She has three children. During her pregnancies, she had to spend much time in bed to control bleeding, yet she had no abnormal postpartum bleeding. Menorrhagia became increasingly worse and seven years ago, she had a hysterectomy. Two years later she began to get progressively weaker and developed severe anemia. A peptic ulcer was suspected. Because she passed tarry stools, a gastric operation was performed. Since then she has had normal blood counts but continues to bruise. She was first studied by me in August 1965. On the basis of her history both clinical and hereditary, and on the laboratory findings (bleeding time, 7.5 min;

TABLE 1—*Aspirin tolerance test in a family having the Minot–von Willebrand syndrome*

Cases		1	2	3	4	5
Bleeding time	min.	2	7	3.5	2	2.5
Bleeding time, after 0.65 gm of acetylsalicylic acid	min.	6	10	5	10	6.5

tourniquet test, 1+; and normal results for the tests of platelet and coagulation function), a diagnosis of the Minot–von Willebrand syndrome was made. She was again studied in August 1966. In the interim she stopped taking acetylsalicyclic acid, whereupon the bruising became less marked.

Case 2. The son of Patient 1 is 21 years old. He had no nosebleeds until 4 years ago; since then they have been spontaneous and severe. He bled after circumcision, after a tooth extraction, and bruises easily.

Case 3. The daughter of Patient 1 is 18 years old. She has a negative bleeding history.

Case 4. The sister of Patient 1 is 41 years old. She has not had nosebleeds nor does she bruise easily but she has always had very heavy menstruation and continues to have. She has four children, three of whom give no evidence of a bleeding history, but one has epistaxis.

Case 5. The son of Patient 4 is 15 years old. He began to have nosebleeds when he was three years old but recently they have become less frequent and severe. The mother made the interesting observation that the nosebleeds are intensified during periods of stress such as exam time. Whether he takes more acetylsalicylic acid during such times was not asked.

The aspirin tolerance test of these five patients is recorded in Table 1. Interestingly, the bleeding time of Patient 1 was prolonged on the first examination. Presumably, she took acetylsalicyclic acid before the interview.

Hemophilia and Hypoprothrombinemia

The bleeding time even in severe hemophilia is normal, yet it is not uncommon to find that a hemophiliac occasionally has a prolonged bleeding time. This has led to confusion and to meaningless terms such as vascular hemophilia. The aspirin tolerance test has been invaluable for clarifying this enigma, as illustrated by two brothers, both of whom are severe hemophiliacs as attested by clotting times over one hour and their concentration of factor VIII of about 0.01% of normal. Yet, one of these brothers has had an exceedingly mild course, and up to the age of 15 has required only two transfusions; he has no crippling joint deformities. In marked contrast, his brother who is

TABLE 2—*Aspirin tolerance test in hemophilia, hereditary hypoprothrombinemia and in the hypoprothrombinemic state induced by bishydroxycoumarin (Dicumarol)*

	Bleeding Time	
	Before (min.)	After Aspirin (min.)
Hemophilia: Case 1	3	3
Case 2	3	15
Hereditary hypoprothrombinemia	4	20+
Bishydroxycoumarin hypoprothrombinemia	2.5	2.5

two years older has required numerous transfusions and is severely crippled from ankylosis in nearly all his large joints. The possible reason for the difference is clearly suggested by the findings recorded in Table 2. The older brother has a poor aspirin tolerance, whereas the other who has a mild clinical course is insensitive to acetylsalicylic acid.

Particularly noteworthy has been the aspirin tolerance test in one of the two brothers who are the first recorded cases of true hereditary hypoprothrombinemia. As seen from Table 2, he had a normal bleeding time but after two tablets of acetylsalicylic acid, his bleeding time was over 30 minutes, in fact, it was difficult to stop the bleeding.

Doctor Quick was unaware of the special issues of the WISCONSIN MEDICAL JOURNAL *being prepared to honor him and Doctor Beckman when he submitted this article. It seemed appropriate to include it in these issues.*—EDITOR

It is interesting to compare the response to acetylsalicylic acid in this patient to that of a subject who has been on bishydroxycoumarin (Dicumarol) therapy continuously for over six years. The latter has a prothrombin time longer than the patient with hereditary hypoprothrombinemia, yet his bleeding time is normal and the aspirin tolerance test likewise is normal. Hemorrhage has not been a problem in the six years he has received bishydroxycoumarin, even though the prothrombin time has occasionally been longer than 30 seconds.

It is to be emphasized that the diagnostic objective in using the aspirin tolerance test is different in the Minot–von Willebrand syndrome than in disorders with coagulation defects such as hemophilia and hypoprothrombinemia. In the syndrome, the test is a direct aid in establishing the diagnosis, whereas in the latter defects, the diagnosis

is made by specific tests such as the prothrombin and the prothrombin consumption times. The aspirin tolerance test has no direct bearing on the diagnosis of a basic coagulation defect, but is merely a means for ascertaining whether the patient is hemostatically sensitive to acetylsalicylic acid.

Comment

Although more acetylsalicylic acid is consumed than any other drug, its pharmacologic action has not as yet been clarified in the 67 years since its introduction into medicine. Particularly puzzling has been its relationship to bleeding, especially in the gastrointestinal tract. Paul and Routh[3] state: "As early as 1899 Dreser stated that irritation and erosion of the stomach mucosa occur from the local action of acetylsalicylic acid." This concept of a physical irritation has become the current explanation for gastric bleeding. When Link and his associates demonstrated that acetylsalicylic acid produced hypoprothrombinemia as measured by the one-stage prothrombin time, a probable new explanation for bleeding came under consideration, but the finding that the prothrombin time became only moderately prolonged and that this required large doses of salicylates made hypoprothrombinemia an untenable explanation.[2]

Strangely, the observation of various investigators that acetylsalicylic acid may increase the bleeding time did not focus attention on the relationship of the bleeding time to hemorrhage. Thus, Gast[4] in a recent report showed by a doubleblind study that the bleeding time was prolonged by the drug. Nevertheless, he states: "This study does not clarify the pathogenesis of ASA-induced faecal blood loss." In another study Pierson and his coworkers[5] using the chromate tagging of red cells technique, showed that in 148 adult patients and volunteer subjects, 73% had significant fecal blood loss. Commenting on their results, they make the significant statement: "The main pharmacologic difference between these compounds lies in acetylation; choline salicylate and sodium salicylate lack the acetyl radical which is maintained in the calcium aspirin compounds. It may be argued, therefore, that the presence of the acetyl group on the salicylic acid molecule is a factor in the induction of gastroinestinal bleeding."

From these statements it is obvious that the findings that acetylsalicylic acid tends to increase the bleeding time and that bleeding may perhaps be associated with the acetyl group were made by others previous to the development of the aspirin tolerance test. But heretofore, no satisfactory correlation of these observations had been made. In searching why this had not been done, one finds two likely reasons: (1) the salicylates have been treated therapeutically and pharmacologically as a group rather than as individual compounds, and (2) the concept of the hemostatic mechanism has not been sufciently inclusive.

How these theoretical reasonings have practical applications can readily be seen. While acetylsalicylic acid and sodium salicylate have certain pharmacologic properties in common, they are nevertheless two separate compounds. The first is readily absorbed intact from the stomach and the upper intestines and acts not as salicylic acid but as an acetylated compound. It is experimentally demonstrable that acetylsalicylic acid affects the bleeding time and that sodium salicylate does not. It appears to have much greater analgesic activity than the non-acetylated compounds of salicylic acid. But it also has the properties of salicylic acid because of rapid hydrolysis in the body. Salicylates have a powerful anti-inflammatory action which makes them so valuable in the treatment of rheumatoid diseases, but Bayles[6] states: "However, there is no evidence that ASA is more anti-inflammatory than non-acetylated salicylates."

To be effective in rheumatic fever and in rheumatoid conditions, maintenance of a high salicylate level in the blood is necessary. This can be effected either by sodium salicylate or by acetylsalicylic acid. To be sure, aspirin will please the patient more because of its greater analgesic effect, but does it benefit him more? Not enough is known to answer this question with certainty; of more consequence is that the hazard of bleeding is much greater. It is well established that acetylsalicylic acid in many individuals not only markedly increases the bleeding time but also increases occult gastrointestinal bleeding and because of the continual slow loss of blood, there results a chronic hypochromic anemia. Therefore, it seems advisable to ascertain by the aspirin tolerance test whether the patient is sensitive to acetylsali-

cylic acid and if he is, to effect the high salicylate level of the blood by using sodium salicylate.

The lack of a more comprehensive concept of hemostasis has hampered the understanding of the relationship of the salicylates to bleeding. Generally, abnormal bleeding is assumed to be due almost exclusively either to a coagulation defect or to a lack of platelets. The control of bleeding by vasoconstriction via the autonomic nervous system has been given little consideration, yet the action of acetylsalicylic acid can best be accounted for by this concept. As a working hypothesis, the failure of the vessels in the microcirculation to contract after injury can best explain the prolonged bleeding time induced by aspirin. This type of hemorrhage is often a slow, continuous oozing, a loss by diapedesis, i.e., by passing through the capillary wall. The mucous membrane seems to be particularly susceptible to this type of hemorrhage. It is not detectable by x-ray studies and because the loss of blood is gradual, no melena results since the escape of blood is slow enough to undergo complete digestion.

In the Minot-von Willebrand syndrome the bleeding after aspirin can be serious. In hemophiliacs and patients with other clotting defects, it may be disastrous if they have poor aspirin tolerance. Before administering acetylsalicylic acid in large amounts, an aspirin tolerance test is strongly recommended if the Minot-von Willebrand syndrome is suspected. In hemophiliacs it is wise not to give any medicine containing acetylsalicylic acid. Another analgesic should be used.

It is not the intent to deprecate the importance and value of acetylsalicylic acid by pointing out its limitations but rather to establish its rightful place in therapy on a sounder basis. Aspirin is a drug and must always be regarded as such. In less than three quarters of a century, it has become the most widely used analgesic and, as far as we know, the safest. As is well known to students of medical history, analgesics are among the most dangerous of drugs. When the need to allay pain is great, indiscrimination in the choice of an agent is often to be expected and the practice of self-medication is frequently the rule. Even such widely used drugs as acetanilide and phenacetin, which were or are found in many proprietary medicines, are known to cause toxic reactions. Others in this group like cinchophen and aminopyrine have wrought such havoc that they are no longer used. Some, like the opiates, are strongly habit-forming which limits their use. Acetylsalicylic acid alone has endured and figuratively prospered. This drug has come as close to being an ideal analgesic as is perhaps possible. If it were not for the inborn error present in the Minot-von Willebrand syndrome, it is doubtful whether the drug would ever cause bleeding. But inborn errors of metabolism do queer things. One such error of metabolism makes the sugar of the most important nutritional fluid—milk—an actual poison, as occurs in galactosemia. In this instance the cure is simple: elimination of milk from the diet. It seems promising that similarly rewarding results will be obtained by keeping patients from taking acetylsalicylic acid if they show a marked sensitivity to the drug as measured by the aspirin tolerance test. Perhaps, too, certain types of unexplained bleeding, menorrhagia, and secondary anemias might then be clarified.

SUMMARY

The aspirin tolerance test has been developed from the observation that the bleeding time is prolonged occasionally in normal subjects and in some patients with hemorrhagic disorders. It has been found to have two important applications: diagnosis, and protection against the untoward effect of acetylsalicylic acid. It assists in establishing the diagnosis of mild cases of the Minot-von Willebrand syndrome, and it helps to lessen the bleeding hazard of patients with established hemorrhagic disorders by detecting those that are aspirin-sensitive.

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Therapy of Trichomoniasis

By ROBERT M. BAKER, M.D.
and ALFRED L. KENNAN, M.D.
Madison, Wisconsin

■ TRICHOMONAS VAGINITIS (vaginitis from trichomonas vaginalis, "trich infection") presents with an irritating malodorous vaginal discharge which offers therapeutic frustration to all physicians who treat gynecologic disorders.

Trichomoniasis must be considered a venereal disease if treatment is to be successful. This concept is supported by the following facts:

(1) The organism has been found in the male genitourinary tract and some observers feel that the incidence in the male nearly approaches that of the female.

(2) Urethritis frequently appears in the male after intercourse with a consort harboring T. vaginalis.

(3) There frequently appears a recurrence of discharge in the male after the reappearance of trichomonas vaginitis in the consort.

(4) Examination of consorts of males with trichomonas urethritis shows that the incidence of vaginitis is close to 100%. Cure is effected only by treatment of the couple simultaneously.

(5) Trichomonal urethritis has been produced by innoculation.

Most methods for the treatment of trichomoniasis in women have been directed locally to the vaginal infestation. Large numbers of chemical, antibiotic and hormonal substances prepared as powders, creams, ointments and lotions testify to the futility of local therapy. Recurrence rates of 50% and higher are commonplace after subsequent menstrual periods.

Failure to eradicate the organism from the urethra and the paraurethral glands of both sexual partners is the primary cause of treatment failure.

From the Department of Gynecology and Obstetrics, University of Wisconsin Medical School.
Doctor Baker is a Resident in Gynecology and Obstetrics. Doctor Kennan is Associate Professor of Gynecology and Obstetrics.

COMMENTS ON TREATMENT

Presented through the cooperation of the Department of Pharmocology, Marquette University, Milwaukee, and the Department of Medicine, University of Wisconsin, Madison

HAROLD F. HARDMAN, M.D., Ph.D., Co-Editor
Marquette University School of Medicine

OVID O. MEYER, M.D., Co-Editor
University of Wisconsin Medical School

A drug to be efficacious must be effective in tissue fluid to reach sites otherwise inaccessible to local therapy and be effective in the urinary tract. Ideally, this would be given systemically.

In 1959, Durel reported successful results with a new systemic agent, a nitroimidazole derivative, called metronidazole. This drug, bearing the trade name Flagyl, has been tested both in vitro and in vivo by Cosar and Julou in Paris. Initial studies revealed the drug to be a potent trichomonacidal agent effective at concentrations as low as 1:400,000. Moreover, this drug has minimal effects on the vaginal flora and a concentration of 1:3000 does not inhibit growth of the Döderlein bacillus in a glucose yeast extract.

Early clinical observations on the efficacy and safety of Flagyl carried out in France, England, and Canada have been confirmed in the United States.

Clinical studies have shown a dramatic clinical response within 48 to 72 hours with clearing of the vulvovaginal symptoms, using 250 mg three times a day for 10 days. The discharge decreases and becomes free of the organism in 4 to 5 days but treatment must be for a longer period to reach accessory glandular areas.

Flagyl has been given to prenatal patients with equally good results. It is recommended that it be used with discretion in pregnant women, especially during the first trimester, although it has been given at all stages of gestation and no harmful effects have been noted in either the mother or the fetus.

Side effects most frequently reported are nausea, vomiting, and an unpleasant taste in the mouth. Occasionally, the symptoms are severe enough to require discontinuation of the medication. Other effects less frequently

reported are anorexia, diarrhea, weakness, fatigue, abdominal discomfort, stomatitis, furring of the tongue, dizziness, headache, urticaria, macular eruption, and pruritus. Infrequent mild leukopenia has been noted. Hepatic function tests during therapy are normal. There is some evidence that Flagyl may enhance the growth of Candida albicans but this has not been a consistent finding.

SUMMARY

Flagyl is an effective drug for the treatment of trichomonas vaginitis and urethritis. It is not effective against Candida albicans. Oral therapy alone is sufficient and makes it possible to deliver effective concentrations of the agent to foci that cannot be reached with local therapy.

Increasing the dose does not raise the cure rate. Retreatment of failures is worthwhile and will raise the cure rate. The incidence of reinfection can be reduced by concurrent treatment of the male partner and this is a recommended procedure.

The effectiveness of Flagyl is not lowered by pregnancy. Administration of Flagyl during pregnancy does not affect the pregnancy or the infant; however, the drug at the present time is not approved for use during pregnancy in the United States.

The side effects are minimal, infrequent, and readily reversible by discontinuation of the medication. The usual recommended dose is 250 mg three times a day for 10 days.*

* A bibliography may be obtained upon request.

SPECIAL TO THE JOURNAL

Lake Pollution and Human Disease

By C. K. KINCAID, M.D.
Madison, Wisconsin

MANY PERSONS are rightly concerned about lake pollution. Many of these have assumed that the scientist who speaks of lake pollution means sufficient contamination to spread disease to people who swim in the lake. Observations on this confusing point in respect to three lakes bordering the city of Madison are offered. Mendota, Monona, and Wingra have surface acreage of 9728, 3456, and 448 respectively, and are quite fertile. Heavy weed growth and considerable algae occasionally annoy boaters, swimmers, and others, especially when these growths wash ashore and putrefy.

Eye, ear, nose, and throat infections are reported from time to time among swimmers. When queried, the medical specialists treating this group have informed me that there is little difference of incidence between users of our lakes and those who swim only in artificial pools.

Doctor Kincaid is Director of Public Health, City of Madison.

Schistosomiasis (cutaneous type) is fairly common in northern lakes in this country. This is a self-limited skin rash caused by invasion of the skin by cercarial forms of the worm which is a parasite of snails. Some years ago a few cases were reported here. The disease here is commonly called swimmer's itch. Treatment of beach areas with copper sulfate kills the snails and the worms die.

Another group of diseases which could spread among swimmers are the enteric infections. These include salmonellosis including typhoid fever, shigellosis, amoebic dysentery, and presumably infectious hepatitis and certain viral infections. In 1964 and again in 1965, letters were addressed to all Madison physicians requesting help in tracing such diseases among swimmers. No cases have been reported to date as being associated with swimming. Viral enteric disease is rarely reported to the health department because of its mildness and because laboratory confirmation is so expensive and difficult.

However, salmonellas, shigellas, and infectious hepatitis are well reported so these were tabulated for the past five years and graphed to show the month of reporting. In the summer months when lake swimming is most enjoyed, that incidence is lowest. This strongly suggests that lake swimming is not a significant source of these diseases.

Streptococcal pharyngitis might be spread in swimming, but this disease virtually disappears in Madison in summer. Over 700 cases occurred last year, but during the lake swimming weeks the reporting drops to the lowest point of the year. The rate begins to climb in October or November, peaks in late winter and slowly declines.

Actions of the health department in posting warning signs at beaches has doubtless contributed to the popular notion that the lakes are unsafe for swimming. Our posting failed to specify reasons.

Sometimes we have posted "No Swimming" signs because we were treating the waters with sodium arsenite or other chemicals to reduce weed growth or to destroy algae. Sometimes we post beaches as a precaution while we treat with chlorine to reduce an inexplicable rise in the coliform index.

When accidents happen in sewage pumping stations or when for other reasons domestic sewage is temporarily emptied into a lake, we have closed nearby beaches as a precaution rather than waiting the 24 or 48 hours required to complete the laboratory work on samples of beach water. On one occasion we did find sewage flowing into Brittingham Bay at the same time the laboratory report showed a rising count. We found that construction people on West Johnson Street had diverted sanitary sewage to the nearest catch basin in order to connect the lateral sewer line to a new building. The catch basin was of course a storm sewer and fed the sewage into the Bay. Brittingham beach was unsafe to swim in for a short time.

In our opinion a rising coliform index does not necessarily mean pollution with domestic sewage nor animal fecal discharges. It is my understanding that there are coliform group bacteria normal to soil (earth). Storm sewers carry this organism from our lawns and some fields to the lakes and this sometimes causes a "high coliform count." An on-shore wind stirs the bottom silt and usually results in a high coliform count. B. polymyxa in silt is a well known cause of false presumptive coliform tests.[1]

In recent years in addition to determining the coli index, our laboratory has been reporting fecal coli and also enterococci. These may be from sources other than human and may or may not indicate presence of pathogens. Since there are no established standards we continue to consider these bacteria as indicators. A rise in chlorides is rather suggestive but this has not been very satisfactory as proof of sewage contamination in lakes because of the relative volume and because of chlorides from several other sources.

At present, then, the armamentarium of our laboratory includes no test procedure which, by itself, is considered conclusive proof of lake pollution with domestic sewage. Therefore we must continue to depend upon multiple testing plus concurrent sanitary inspection of the environment of beaches. We are aided by a reporting system established a few years ago by which the City Engineer's office and the Metropolitan Sewage District office notify us of any accidental or emergency bypassing of sanitary sewage into the lake. Included in these reports are the date and hour of starting and stopping, the cause of the trouble, and an estimate of the gallonage.

In the APHA manual[2] on public bathing places, three aids are named on page 47 for evaluation: (1) chemical analyses, (2) bacteriological analyses, and (3) sanitary survey including flow currents, etc. "It is not considered practicable nor desirable to recommend any absolute standard of safety for the waters of outdoor bathing places on any of the three above bases. The arbitrary wholesale condemnation of bathing beaches representing large capital investments is unwarranted without definite epidemiologic evidence."[2]

On page 51 we read ". . . that bacterial quality standards which may seem somewhat strict may be recommended in cases where there is no intention of applying 'Quarantine' until significant detrimental effect on the health of bathers is demonstrated or clearly threatened."[2]

Then on page 52 we find, "It is emphasized that final classification of bathing waters should depend largely upon sanitary survey information."[2]

Of equal interest, and my final quotation, is on page 53, "Bathing in streams or ponds subject to gross animal pollution is not approved because of the possible danger of animal-borne virus diseases. At the same time, many inland waters have been found to show high figures for content of coliform organisms due to the effects of pasturage and contamination from wild animals rather than human sewage pollution, and it has not been demonstrated that adverse health effects have resulted from bathing in such waters. This again calls attention to the need for considering both analytical findings and sanitary survey data."[2]

Most persons are interested in "clean waters" and an unpolluted lake, and will give moral and financial support to efforts to "save the lake." There may be simply a semantic problem between the taxpayer and swimmer and the technical people. We speak of pollution as including any substance which doesn't belong there. The citizen evidently thinks pollution means unsafe for swimming. Last year a girls' team using the lake became chagrined when a competing team at a pool is said to have refused to enter a swimming meet unless all swimming would be done at the pool "to avoid the polluted beach." Yet all summer long that beach water was in fine shape and in my opinion less likely to cause human disease than the specified pool or almost any other artificial pool.

Here then we have a curious and saddening picture of safe lakes in which to swim but to some degree the community and its physicians believe that they are the source of human disease. On the other hand we see many safeguards and surveillance systems functioning with obvious success to prevent disease. Lastly there is in recent years a total absence of epidemiologic evidence of infection incident to beach bathing which would have been avoided by use of a pool.

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THE PRESIDENT'S PAGE

HAROLD J. KIEF, M.D.

SMS means aggressive leadership

"First to know and then to utter"

■ THIS MONTH THE State Medical Society of Wisconsin, through the *Wisconsin Medical Journal,* is honoring two of its distinguished members—Dr. Harry Beckman and Dr. Armand J. Quick of Milwaukee.

These doctors have brought honor and worldwide acclaim to themselves, their university, Marquette, and to our State of Wisconsin. But more significantly they have brought health to countless millions of patients through us, their students. Yes, I believe almost all practitioners are their students, not always formally but certainly by reading their papers, listening to their lectures, and reading their books.

On other pages of this issue of the *Journal,* and in the July issue, one can read of their accomplishments as scientists, researchers, physicians, authors, and educators. But of all the attributes of these two famous physicians, the quality which I believe we all must admire most, if one can be chosen, is that of educator.

It has been said that a true educator has two characteristics: "first to know and then to utter." And this is true of the two physician–educators we are honoring now. They know their subjects well and are able to deliver their knowledge to others with refreshing, crisp, and personal styles of their own.

As true teachers would, they have continued this task of teaching even though they both have retired from Marquette medical school. This is evidenced by the articles of Doctor Beckman and Doctor Quick in these commemorative issues of our *Journal.* Doctor Beckman's article is the first of a series on "Therapeutic Dilemmas" which will appear bimonthly.

Truly in these men it can be said that the "desire of knowledge ever increased with the acquisition of it." But it is also true that their basic philosophy in disseminating this knowledge has remained an integral part of their character—the character of a true educator.

Both Doctors Harry Beckman and Armand Quick have received national and international recognition and fame. Awards have been given to both doctors from foreign countries and from medical groups in this country. Our State Medical Society has given these eminent physician-educators our "Council Award"—the highest honor accorded anyone by our Society.

What is left? How can we honor Doctor Beckman and Doctor Quick now? Let us, the doctors of Wisconsin, honor them in a lasting and positive way—a way they taught us. These two physician–educators did not wait for federal grants. They did not wait until the very brink of disaster to research and then discover. But rather they progressed through the years to give better service—better service to a sick patient.

Let us honor them in a way we've been taught: by every member of SMS pledging himself to acquire new knowledge and to develop new methods of delivering this knowledge to his patients. As every member of the State Medical Society fulfills this pledge, he will be honoring you—Dr. Harry Beckman and Dr. Armand Quick.

H J Kief MD

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EDITORIALS

D. N. GOLDSTEIN, M. D., *Editorial Director*

Freedom to Choose

■ THE RIGHT OF A PATIENT—or a guardian of a patient—to refuse medical treatment recommended by a physician is one that some doctors seem reluctant to recognize. This fact comes to public notice when a court is petitioned to assume custody of a minor so that a doctor's recommendation of a course of treatment, rejected by a parent, can be carried out. A complaint judge accepts the doctor's allegation that the procedure he prescribes is the only one that will save the patient's life, and the medical profession's claim to powers of life-and-death is buttressed. Most frequently, the issue is a blood transfusion involving a patient who has a religious scruple against such therapy.

Through experience doctors have learned that many patients cannot comfortably handle technical information about their own cases without becoming either too apprehensive or trying to interfere with the details of therapy. As a result, from the patient's point of view medical science is an arcane system that expresses itself in its own gibberish, a barely legible incomprehensible prescription slip, and a carefully worded, oversimplified statement of what the problem seems to be. In some hospitals the veil of mystery is so tightly drawn that nurses will hardly tell the patient the time of day without a doctor's order. The patient can't avoid the frightening impression that illness places him at the mercy of a demi-god who requires him only to submit his body and pay the bill.

Despite this professional attitude, most patients are cooperative, recognizing that modern medicine is indeed a highly technical matter for which a very specialized knowledge is necessary. They rely on the integrity of physicians in whose hands they placed themselves, and, happily, the results more often than not justify the confidence demanded of them. Besides, there isn't much they can do about it once they find it necessary to enter into a doctor–patient relationship. Thus, by virtue of this special posture, doctors are relieved of the necessity of discussing, or perhaps debating, the merits of some procedure with a patient who may not be equipped to understand properly the values involved. Also, as a result, medical practitioners often appear to insist on the sacrosanctity of their opinion.

Some therapy offends the religious scruples of certain groups. Christian Scientists reject much medical treatment and, notoriously, Jehovah's Witnesses and other similar fundamentalist sects refuse blood transfusions on religious grounds. The right of these people to decline a particular course of treatment should be respected. No matter how certain he is that the therapy he recommends is the only one that will preserve life, no physician has the moral right to over-ride a patient's religious scruple against the use of that therapy. Nor does he have a moral right to refuse to continue to treat a patient who rejects his recommendation for any reason except the most frivolous.

When the obligation to save life conflicts with the obligation to respect a religious scruple that may result in the loss of life, the doctor's decision is indeed a difficult one. Those who have sought legal aid to enforce their recommendations have clearly placed a higher value on survival than on personal integrity. They have proclaimed that adherence to principle is of less value than continued existence. Doctors taking this position have denied the sacrifices of all the martyrs that have glorified history with their supreme devotion to principle even at the expense of their own lives. For those patients who choose certain death rather than violate a religious scruple are of the same stuff as those who paid with their lives for faith in God or who went to the stake rather than accept baptism. Even more agonizing is the situation created by rejection of treatment in behalf of a minor. Undoubtedly lives have occasionally been saved by virtue of coercive blood transfusion but soul-searching of the highest order is mandatory before seeking usurpation of parental rights.

Ours is the duty to save life but we may well question whether we do not also have a duty to safeguard integrity and preserve the few gestures of personal authenticity that continue to occur in an increasingly regimented society. It is one thing to save a psychotic from the violence of his own derangement, but it is quite another to interfere with the act of faith of a mature, emotionally stable human being whose life is validated by his devotion to an ideal. No doctor should seek legal assistance to save a body by destroying a soul.

The patient's life is his own. His freedom of choice with regard to its continuance should not be eroded by the state, particularly at the insistence of the medical profession which has been so prickly about governmental nibbling at its own freedoms.

—D.N.G.

LETTERS

DESPERATE PLEA FOR FAMILY PHYSICIAN

To the SOCIETY:

(EDITOR'S NOTE: *The Society routinely acknowledges the death of a member physician to his next of kin and includes information that may be of help in settling the physician's affairs. Included also is an obituary notice for approval in publishing in the Journal. The next of kin, usually the widow, returns the notice with an accompanying letter which affords the widow opportunity to express her thoughts concerning medicine as it related to her husband. One such letter was received recently and is printed below, in part, because of its frank and sincere remarks on a subject that has been troubling the medical profession for some time.)*

. . . There is one thing I wish I could do something about. In my moments of bitterness over losing ____ so soon, I have been about ready to dash to Madison to plead with University authorities to set up a good course for G.P.'s—encourage young men to enter this phase of medicine. Why frighten them into thinking they don't know enough? If they are taught to diagnose a case, surely no one will tackle something he cannot handle. The need for doctors in the rural areas is tremendous. Maybe if we would have had help here, _____ might have been given a few more years. Lord only knows he was too, too tired to carry on any longer. My version of the modern trend of medicine is—diagnose one's own case so he will know which doctor to go to. Can't someone give us a family physician who knows his patient as a *friend* in need of treatment and not a number so and so who is tossed from one doctor to another to be put through the same tests all for a *single* diagnosis? L.B.J.'s great ideas for large heart centers, etc., are nightmares. We are still human beings who find courage and hope during time of illness by being near our loved ones and do not want to be herded off to distant places for treatment.

Oh forgive me for being so carried away with my thoughts; but it is something I firmly believe. Will the pendulum ever swing back before we lose all our family physicians?

—A DECEASED PHYSICIAN'S WIDOW

Losing Rapport With the Chief of Staff??

If you find yourself irritable lately, you may be suffering from ennui miserable *or "Late-Summer Jumpies." If so, here's a combination of medically approved ingredients to bring you incredibly fast relief.*

Take the family on a Get-Away Weekend to Prairie du Chien and the Museum of Medical Progress. Spend an air-conditioned, lazy day browsing amid the 13th Century Dutch "Gapers," the well-stocked 1890 drugstore, dioramas, audio-visual displays and the colorful reminders of those who brought greatness to Wisconsin medicine.

Then take in "Prairie." Stay overnight in a clean little motel. Swim in the municipal pool. Try a boatride on the Mississippi. Have a picnic on the Museum lawn. Relax. We promise you'll come home liking everybody better . . . including yourself.

The Museum of Medical Progress and Stovall Hall of Health

Prairie du Chien, Wisconsin

Owned and operated by the Charitable, Educational & Scientific Foundation of the State Medical Society of Wisconsin.

WISCONSIN PHYSICIANS SERVICE reports . . .

WPS PAYS $7 MILLION IN MEDICARE BENEFITS

Since July 1, 1966, Wisconsin Physicians Service, a division of the State Medical Society of Wisconsin, has been administrative carrier for the voluntary surgical-medical portion of Medicare, commonly known as Medicare Part B. Under Medicare Part B, persons over 65 who enroll may receive surgical-medical coverage for $3 per month with the government paying an equal amount. WPS administers Medicare Part B throughout Wisconsin, except Milwaukee County.

MEDICARE PART B PAYMENTS

During the first 12 months of Medicare, a total of 431,873 Medicare Part B claims were sent to WPS and WPS paid $7,669,079 in benefits.

There is a carry-over provision which states that any charge which is incurred during the last three months of a calendar year and is properly applicable to the $50 deductible for that calendar year will also be credited to the next calendar year's deductible. Any charges incurred in July, August, and September of 1966 **DO NOT** carry over to 1967. Those charges that are incurred and properly applied to the deductible in October, November, and December of 1966 **DO** carry over. If the patient has only one claim in 1966—$50 in August—that amount will be applied to the 1966 deductible. Whenever he has a claim in 1967, he will have to meet his $50 deductible again. However, if that claim was in October instead of August, it would be applied to the 1966 deductible, but it would also meet his deductible for 1967. Therefore, he would receive an 80 per cent benefit on the first claim he would have in 1967.

The following hypothetical case will illustrate the process of payment for medical care expenses covered by Medicare Part B.

1. Sixty-six year old Mr. Brown enrolls in Medicare Part B.
2. Mr. Brown incurs medical care expenses covered by Part B totaling $35.
3. Mr. Brown's physician, who accepted the assignment, sends a Social Security Request for Payment form (SSA Form 1490) to WPS.
4. The $35 is credited toward Mr. Brown's $50 deductible.
5. Mr. Brown incurs additional medical care expenses covered by Part B totaling $45. This brings Mr. Brown's total medical care costs covered by Part B Medicare to $80.

6. Mr. Brown has now fulfilled the $50 deductible requirement of Medicare Part B. He has also incurred expenses of $30 beyond the $50 deductible. This means that Medicare will pay 80 per cent of this $30 medical care cost or $24. Mr. Brown will pay 20 per cent of this cost or $6 in addition to the deductible.

If the Request for Payment form (SSA Form 1490) is filled out completely and accurately, the process for payment or notification of Medicare Part B beneficiaries should take approximately 20 days.

PHYSICIANS URGED TO USE FORM 1490

The SSA Form 1490 is designed to be used by physicians, whether or not they take Medicare assignments.

There are two methods of payment under Medicare Part B insurance. When the physician agrees, the "assignment" method may be used. The physician sends the Request for Payment form to the carrier and bills the beneficiary only for the part of the bill that Medicare does not cover. With the second method, the same Request for Payment form is used, but the patient, or the physician, sends the claim to the carrier after the bill is paid.

When the beneficiary sends the claim to the Medicare carrier, he fills out the first part (Part I) of the Request for Payment form and the doctor completes the second part of the form showing the services and the charges to the patient. If the doctor does not fill out the second part of the form, the beneficiary must enclose an itemized, receipted bill. When a bill is enclosed, it is very important that it show not only the charges, but what specific services were given to the patient and on what date. The bill must also be marked paid.

A beneficiary who sends in an itemized, receipted bill should also be very careful to complete all blanks on the top part (Part I) of the Request for Payment form including the "description of illness." Here, the beneficiary should simply indicate why he went to the doctor or, in his own words, what his illness or injury is.

According to the Social Security Administration, the use of the 1490 form is the most convenient method of providing the receipted bill needed for paying Medicare claims, and assures that all information needed is available.

The SSA also urges the use of the form to speed up claims payment by eliminating the need for more correspondence.

WPS PAYS $8 MILLION IN MEDICAID BENEFITS

WPS is also administrative contractor for the Wisconsin Medical Assistance Program. Under this State-sponsored program known as Title XIX (or Medicaid), WPS pays claims on behalf of medically indigent Wisconsin residents, except those in Milwaukee County.

The Wisconsin Medical Assistance Program extends medical care to many who are not recipients of money payments under the public assistance program. These are often persons whose incomes are adequate to meet their normal daily needs, but who do not have sufficient money left over with which to buy necessary medical services.

For example, it is estimated that over 232,000 children in Wisconsin are living in families with marginal incomes. Their incomes are large enough to prevent them from becoming eligible for aid to families with dependent children, but are not large enough to assure that basic medical services will be provided when necessary.

From August, 1966 through June, 1967, a total of 626,088 Medicaid claims were processed by WPS. Payment to providers of Medicaid totaled $8,798,928.

WHERE AND WHEN TO APPLY FOR MEDICAID

Persons who wish to apply for the Wisconsin Medical Assistance Program may apply at their county welfare department. Applications may be submitted anytime, regardless of health or illness. A person's eligibility may be determined on the basis of the application prior to any need for health care services.

ELIGIBILITY FOR MEDICAID

County departments of public welfare determine the eligibility of applicants for benefits under the Medical Assistance Program. The county welfare departments will then notify the contractors of eligibility and issue eligible persons a certification card.

There are two groups of Medicaid beneficiaries. Group I beneficiaries are recipients of Social Security aids. These are individuals or families who are approved for a money grant under the four aid categories and are automatically eligible for Group I benefits. The four aid categories are Old Age Assistance, Blind Aid, Disabled Aid, and Aid to Dependent Children.

Group II beneficiaries are Medical Assistance **only** beneficiaries. These beneficiaries are Wisconsin residents, including those absent from the State, and must meet the following requirements:

1. Sixty-five years of age or older;
2. Totally and permanently disabled as defined by the State Department of Public Welfare and are 18 years of age or over;
3. Blind, as defined by the State Department of Public Welfare regardless of age;
4. Under 21 years of age or a parent or relative regardless of age with whom an eligible child is living and who would be eligible for Aid to Dependent Children money grants if in need.

Beneficiaries of the Wisconsin Medical Assistance Program must also meet the following requirements regarding income and property and resources:

1. An annual income of $1,800 or less for a single person;
2. An annual income of $2,700 or less for a family of two; ($500 is allowed for each legal dependent).
3. Property or resources must not be in excess of $2,300 if single, $3,000 if a family of two and $500 is allowed for each legal dependent over and above exempt property.

In addition, eligible persons may have a home and land, household or personal possessions such as an automobile.

Persons who have income and resources exceeding the above could become eligible for medical assistance at the time their income is reduced to the limits cited because of payment of health care bills.

After eligibility for Medical Assistance is determined by the county welfare department, Group I beneficiaries are issued a yellow certification card and Group II beneficiaries are issued a green certification card.

For rapid processing of Title XIX claims, Medicaid beneficiaries should only show their Medical Assistance certification card to their doctor, hospital, druggist, or other provider of care when receiving health care services which are payable through Medical Assistance.

OTHER INFORMATION

Persons having questions concerning Medicare benefits should write to Medicare Part B, Wisconsin Physicians Service, Box 1109, Madison, Wisconsin, 53701, or call Medicare Part B at 1–608–257–0761.

Persons having questions concerning Medicaid or the Wisconsin Medical Assistance Program (Title XIX) should visit their county welfare department or write to the State Department of Public Welfare, Division of Public Assistance, One West Wilson Street, Madison, Wisconsin, 53702. These persons may also write Wisconsin Physicians Service, Box 1109, Madison, Wisconsin, 53701, or telephone 1–608–257–0262.

WPS
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COLLECTED PAPERS . . ARMAND J. QUICK, M.D.

HEMOSTASIS AND HEMORRHAGIC DISEASES

1934

1. Anticoagulants of the blood, Proc. Soc. Exp. Biol. & Med. 32:164–165, October (with F. W. Bancroft and M. Stanley–Brown)

1935

2. The prothrombin in hemophilia and in obstructive jaundice, J. Biol. Chem. 109: lxxiii–lxxiv, May
3. Postoperative thrombosis and embolism, Am. J. Surg. 28:648–668, June (with F. W. Bancroft and M. Stanley–Brown)
4. On the relationship between complement and prothrombin, J. Immunology, 29:87–97, August
5. A study of the coagulation defect in hemophilia and in jaundice, Am. J. Med. Sci. 190:501–512, October (with M. Stanley–Brown and F. W. Bancroft)

1936

6. On various properties of thromboplastin (aqueous tissue extracts), Am. J. Physiol. 114:282–296, January
7. On the action of heparin and its relation to thromboplastin, Am. J. Physiol. 115:317–333, April
8. The coagulation defect in peptone shock and in sweet clover disease, J. Biol. Chem. ?: lxxxii, May
9. On the coagulation defect in peptone shock; a consideration of antithrombins, Am. J. Physiol. 116:535–542, August
10. Is heparin an antiprothrombin?, Proc. Soc. Exp. Biol. & Med. 35: 391–392, December

1937

11. The coagulation defect in sweet clover disease and in the hemorrhagic chick disease of dietary origin. A consideration of the source of prothrombin, Am. J. Physiol. 118:260–271, February
12. Quantitative determination of prothrombin, J. Biol. Chem. 119: lxxxi (with M. Leu)
13. The relationship of the antithrombogens, heparin and calcomine fast pink, to the antithrombin normally occurring in blood, J. Biol. Chem. 119: lxxxi, July

1938

14. Qualitative differences in the prothrombin, thromboplastin, and thrombin in different species, J. Biol. Chem. 120:xcix, May
15. The nature of the bleeding in jaundice, J.A.M.A. 110:1658–1662, May 14
16. The normal antithrombin of the blood and its relation to heparin, Am. J. Physiol. 123:712–719, September

1939

17. Calcium factor in quantitative determination of prothrombin, Proc. Soc. Exp. Biol. & Med. 40: 206–208, February
18. The concentration of prothrombin in infant blood, J. Biol. Chem. 41:lxxx
19. Concentration of prothrombin in blood of babies (3 to 7 days old), Proc. Soc. Exp. Biol. & Med. 40: 647–648, April (with A. M. Grossman)
20. Prothrombin concentration in newborn, Proc. Soc. Exp. Biol. & Med. 41:227–228, May (with A. M. Grossman)
21. The clinical significance of prothrombin as a factor in hemorrhage, Pennsylvania Med. J. 43: 125–130, November
22. Determination of prothrombin, Proc. Soc. Exp. Biol. & Med. 42: 788–789, December

1940

23. The nature of the hemorrhagic disease of the newborn; delayed restoration of the prothrombin level, Am. J. Med. Sci. 199:1–?, January (with A. M. Grossman)
24. A classification of hemorrhagic diseases due to defects in the coagulation mechanism of the blood; based on recently published studies, Am. J. Med. Sci. 199:118–?, January
25. The clinical application of the hippuric acid and the prothrombin tests, Am. J. Clin. Path. 10: 222–233, March
26. The prothrombin in preserved blood, J.A.M.A. 114:1342–1346, April
27. Assay method for vitamin K, J. Biol. Chem. 133:lxxviii
28. A clinical classification of hemorrhagic diseases, due to coagulation defects, Wisconsin Med. J. 39: 517–521, July
29. The thromboplastin reagent for the determination of prothrombin, Science 92:113–114, August
30. Calcium in the coagulation of the blood, Am. J. Physiol. 131:455–464, December

1941

31. Therapeutic value and limitations of vitamin K, Nebraska State Med. J. 26:1–4, January
32. The prothrombin concentration in the blood of various species, Am. J. Physiol. 132:239–244, February
33. The diagnosis of hemophilia, Am. J. Med. Sci. 201: 469–474, April
34. Contribution of the laboratory to the treatment of hemorrhage, Illinois Med. J. 79:?, April
35. Prothrombin level of blood after the intramuscular injection of sodium citrate, Proc. Soc. Exp. Biol. & Med. 47:1–3, May
36. Vitamin K (guest editorial), Virginia Med. Monthly 68:621–?, November
37. Metathrombin in circulating blood, J. Biol. Chem. 140:cxlvi

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38. Comparison of the action of Russell viper venom with that of thromboplastin, Fed. Proc. 1:131–132, March
39. Effect of air currents on plasma prothrombin, Proc. Soc. Exp. Biol. & Med. 50:317–318.
40. The present status of the hemorrhagic diseases, Minnesota Med. J. 25:775–778, October
41. Differentiation of the hemorrhagic diseases, Hospital Progress 23:378–380, December

1943

42. Heparin and the agglutination of platelets *in vitro*, Proc. Soc. Exp. Biol. & Med. 53:173–174, June (with I. D. Baronofsky)
43. On the constitution of prothrombin, Am. J. Physiol. 140:212–220, November

1944

44. Effect of heparin on the thrombopenia of anaphylactic and peptone shock, Fed. Proc. 3:62, March (with R. K. Ota and I. D. Baronofsky)

1945

45. Prothrombin of newborn pups born of a mother fed Dicumarol, Fed. Proc. 4:101, March
46. Hemophilia-like disease in the female; with a note on the clotting time of the recalcified plasma, Am. J. Med. Sci. 209:443–447, April (with F. W. Madison)
47. Experimentally induced changes in the prothrombin level of the blood. I. Quantitative studies in dogs given Dicumarol. II. The effect of methylxanthines on prothrombin *per se* and when administered with Dicumarol, J. Biol. Chem. 161:33–44, November
48. On the quantitative estimation of prothrombin, Am. J. Clin. Path. 15:560–566, December

1946

49. Effect of synthetic vitamin K and of quinine sulfate on the prothrombin level, J. Lab. & Clin. Med. 31:79–84, January
50. On the thrombopenia of anaphylactic and peptone shock Am. J. Physiol. 145:273–278, January (with R. K. Ota and I. D. Baronofsky)
51. Influence of decalicification on the determination of prothrombin, Fed. Proc. 5:150, February
52. The coagulation of the blood; theoretical and practical aspects, Proc. Inst. Med. of Chicago 16: 94–112, March
53. Dicumarol in the treatment of thrombosis and embolism, Kansas City Med. J. 22:5–7 March
54. The components of prothrombin, Proc. Soc. Exp. Biol. & Med. 62: 249–250, June
55. Experimentally induced changes in the prothrombin level of the blood. III. Prothrombin concentration of newborn pups of a mother given Dicumarol before parturition, J. Biol. Chem. 164: 371–376, July
56. Etat actuel de nos connaissances sur la prothrombine, Sang 17: 281–291
57. Hemorrhagic diatheses (editorial), Dig. Treatment 10:368–369, December

WE ACKNOWLEDGE with deep appreciation the assistance given by Miss Mary Dougherty of the Milwaukee Academy of Medicine in furnishing us with the bibliographies, biographical material, and pictures.—EDITORS

ARMAND J. QUICK *continued*

1947

58. On the quantitative relationship between calcium and prothrombin, Am. J. Physiol. 148:211–221, January
59. Quantitative studies on the coagulation defect in hemophilia, Fed. Proc. 6:284, March
60. On the quantitative relationship between the concentration of calcium and the coagulation of the blood, Fed. Proc. 6:295, March (with M. Stefanini and M. C. Blanchaer)
61. Congenital hypoprothrombinaemia and pseudo-hypoprothrombinaemia, Lancet 2:379–386, September
62. Studies on the enigma of the hemostatic dysfunction of hemophilia, Am. J. Med. Sci. 214:272–280, September
63. The relation of fibrinogen to the coagulation factor which diminishes in stored plasma, Am. J. Physiol. 150:405–408, September (with R. Honorato)
64. Components of the prothrombin complex, Am. J. Physiol. 151: 63–70, November
65. Classification of congenital hypoprothrombinemias, Milwaukee Med. Times 20:37–39, December
66. Is the action of calcium in the coagulation of blood stoichiometric or catalytic?, Science 106:591, December

1948

67. Activation of plasma thromboplastinogen and evidence of an inhibitor, Proc. Soc. Exp. Biol. & Med. 67:111–112, January (with M. Stefanini)
68. Quantitative studies on the comparative activity of calcium and chemically related ions on the coagulation of blood, Am. J. Physiol. 152:389–396, February (with M. Stefanini)
69. Role of platelets in coagulation of blood evidence of an inhibitor of the platelet factor, Fed. Proc. 7:180, March
70. The concentration of the labile factor of prothrombin in the blood of various species, Fed. Proc. 7:191, March (with M. Stefanani)
71. Surgical aspects of hemorrhagic diseases, Northwest Medicine 47: 186–190, March
72. A modern concept of the coagulation of blood, Marquette Med. Rev. 13:89–94, April
73. The concentration of the labile factor of the prothrombin complex in human, dog, and rabbit blood; its significance in the determination of prothrombin activity, J. Lab. & Clin. Med. 33: 819–826, July (with M. Stefanini)
74. Experimentally induced changes in the prothrombin level of the blood. IV. The relation of vitamin K deficiency to the intensity of Dicumarol action and to the effect of excess vitamin A intake; with a simplified method for vitamin K assay, J. Biol. Chem. 175:945–952, September (with M. Stefanini)
75. The value and limitations of the coagulation time in the study of the hemorrhagic diseases, Blood 3:1120–1129, October (with R. Honorato and M. Stefanini)
76. The chemical state of the calcium reacting in the coagulation of blood, J. Gen. Physiol. 32:191–202, November (with M. Stefanini)
77. The effect of heparin on platelets *in vivo*, J. Lab. & Clin. Med. 33: 1424–1430, November (with J. N. Shanberge and M. Stefanini)
78. The coagulation defect in thrombocytopenic purpura, J. Lab & Clin. Med. 33: 1479–1480, November (with J. N. Shanberge and M. Stefanini)
79. Recent advances in the treatment of hemorrhagic diseases, Mississippi Doctor 26:180–184, December

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80. The congenital types of hypoprothrombinemia; a consideration of the clinical picture and hereditary pattern, Chicago Med. Soc. Bull. 51:614–616, February
81. The role of platelets in the coagulation of the blood, Am. J. Med. Sci. 217:198–205, February (with J. N. Shanberge and M. Stefanini)
82. New concept of hemophilia, Chicago Med. Soc. Bull. 51:703–705, March
83. Clinical consideration of vitamin K and hypoprothrombinemia, Chicago Med. Soc. Bull. 51:706–708, March
84. Pediatric aspects of hemophilia, Pediatrics 3:312–317, March
85. Prothrombin consumption test, Fed. Proc. 8:239, March (with J. E. Favre-Gilly)
86. Effect of various adsorbents on the components of the prothrombin complex, Fed. Proc. 8:255, March (with M. Stefanini)
87. The coagulation defect in thrombocytopenic purpura, J. Lab & Clin. Med. 34:761–767, June (with J. N. Shanberge and M. Stefanini)
88. Venous thrombosis, Bull. Potter County Med. Soc. 3:6, June

WILLIAM S. MIDDLETON, M.D.

MADISON, WISCONSIN

Dear Harry:

When I learned of the design of the Editors and Editorial Board of the Wisconsin Medical Journal to honor you, I rejoiced in the opportunity to add my small voice to the host from Marquette University, the University of Wisconsin, the medical profession of the State and the country at large, who will swell the chorus.

In the main, your contribution has been in the field of medical education, where it is sorely needed. Whether in the classroom, the clinic, or the medical meeting, you have held your audience in wrapt attention by your masterly grasp of your subject and by your splendid capacity for lucid exposition. A teamworker whose gracious acceptance of such assignments as the co-editorship of "Comments on Treatment" in the Wisconsin Medical Journal carried invaluable information to your associates in the field, you well merit the esteem in which you are held by them. Your "Treatment in General Practice" has been a stalwart ally over the years, as have been your other publications. In a period when detail men from reputable pharmaceutical houses have too frequently been the sole source of information on drugs and drug action for the practitioner, you have literally been "the prophet crying in the wilderness."

Now my measure of appreciation, Harry. May your torch be held high as a shining example of the traditional teacher to our profession.

Affectionate regards.

Sincerely yours,

Bill

WILLIAM S. MIDDLETON, M.D.
Emeritus Dean, University of Wisconsin Medical School

89. The concentration of component A in blood, its assay and relation to the labile factor, J. Lab. & Clin. Med. 34:973–982, July (with M. Stefanini)
90. The physiology of intravascular clotting, Jackson Clin. Bull. 11, 117–120, July
91. Fibrin, a factor influencing the consumption of prothrombin in coagulation, Am. J. Physiol. 158: 387–395, September (with J. E. Favre–Gilly)
92. The state of component A (prothrombin) in human blood; evidence that it is partly free and partly in an inactive or precursor form, J. Lab. & Clin. Med. 34: 1203–1215, September (with M. Stefanini)
93. Effect of Dicumarol on concentration of the labile factor, Proc. Soc. Biol. Exp. & Med., 72:232–234, October (with M. Stefanini)
94. The coagulation mechanism; with specific reference to the interpretation of the prothrombin time and a consideration of the prothrombin consumption time, Am. J. Clin. Path. 19:1016–1023, November
95. Les conditions de la conversion de la prothrombine dans le serum apres la coagulation, Rev. hemat. 4:433–463 (with J. E. Favre–Gilly)
96. Hemophilia in twins, Am. J. Med. 7:841–843, December (with J. P. Conway)
97. The prothrombin consumption test; its clinical and theoretic implications, Blood 4:1281–1289, December (with J. E. Favre–Gilly)
98. The prothrombin activity of human blood, J. Lab & Clin. Med. 34:1739–1740, December (with M. Stefanani)

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99. Nature of action of the labile factor in formation of thrombin, Am. J. Physiol. 160:572–575, March (with M. Stefanini)
100. Effect of surface on coagulation reactions, Fed. Proc. 9:216–217, March
101. Methode en un temps pour l'estimation de la consommation de la prothrombine dans le caillot et le serum, Sang 21:630–634 (with J. E. Favre–Gilly)
102. Effect of sodium citrate and heparin on removal of calcium from blood and serum by amberlite, J. Biol. Chem. 184:105–108, May (with C. V. Hussey, M. Stefanini, C. F. Consolazio, and F. Sargent)
103. The coagulation mechanism, Wisconsin Med. J. 49, 613–614, July
104. Venous thrombosis with special reference to the phlebothrombotic type, Rocky Mountain Med. J. 47:585–591, August
105. A new concept of venous thrombosis, Surg. Gynec. & Obstr. 91: 296–300, September
105a. Un nuevo concepto sobre trombosis venosa, El Dia Medico 22: 1–8, 1950
106. A new concept of the clotting of the blood and the hemorrhagic diseases, J. Missouri State Med. A., 47:749–753, October
107. Practical aspects of hemophilia, J. Insurance Med. 5:25–29, October
108. The mechanism of clot retraction, Science 112:558–559, November (with C. V. Hussey)
109. Clot retraction; its physiological and clinical significance, Am. J. Med. Sci. 220:538–546, November
110. The common hemorrhagic diseases of childhood, Minnesota Med. 33:1098–1101, November
111. The role of vitamin K in the formation of prothrombin, J. Lab. & Clin. Med., 36:976, December (with G. E. Collentine)

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112. Management of hemophilia in general practice, J.A.M.A. 145: 4–8, Jan. 6
113. Modern concepts of venous thrombosis, The Practitioner 166: 213–222, March
114. Role of vitamin K in the synthesis of prothrombin, Am. J. Physiol. 164:716–721, March (with G. E. Collentine)
115. Ratio of free to total prothrombin in various types of hypoprothrombinemia, Fed. Proc. 10:235, March (with C. V. Hussey)
116. Influence of concentration of thromboplastin on prothrombin time of human and dog plasma, Proc. Soc. Exp. Biol. & Med. 76: 732–734, April (with C. V. Hussey)
117. The interrelationship of vitamin K and dicoumarin, Am. J. Med. Sci. 222:7–12, July (with G. E. Collentine)
118. Las enfermedades hemorragicas debidas a trastornos de la coagulacion, El Dia Medico 23:2102–2109, August
119. On the comparative prothrombin activity of human and dog blood, J. Clin. Invest. 30:903–907, September (with C. V. Hussey)

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120. The effect of heating on the thromboplastic activity of rabbit brain extract, a new test for the diagnosis of hemophilia, J. Lab & Clin. Med. 39:142–147, January (with W. F. Stapp and C. V. Hussey)
121. Is hypoprothrombinemia caused by deficiency of vitamin K different from that of Dicumarol?, Proc. Soc. Exp. Biol. & Med. 79: 131–133, January (with C. V. Hussey and G. E. Collentine)
122. Bile and the absorption of vitamin K_1, Fed. Proc. 11:272, March (with C. V. Hussey)
123. Hemophilia; clinical and laboratory observations relative to diagnosis and inheritance, Am. J. Med. Sci. 223:401–413, April (with C. V. Hussey)

WILLIAM S. MIDDLETON, M.D.

MADISON, WISCONSIN

Dear Armand:

My heartiest congratulations on this felicitous occasion. National and international recognition has been your lot; but there is something special in the acclaim of your home folks—and this expression of esteem and affection is given without reservation.

Seldom in our modern society is a worker in the basic science of biochemistry singled out from his associates in academic medicine for such public notice. I have no doubt that your educational Odyssey from your native Theresa to Wisconsin, Illinois, Pennsylvania, Cornell and Vanderbilt vastly extended your prospect before your return to Marquette. Certainly the internship at Old Blockley (Philadelphia General Hospital) left its hallmark in the practical bent of your subsequent research.

The real scientist is primarily a man of discriminating insight, who instinctively separates the wheat from the chaff. Your sustained studies of the coagulative system have borne rich harvests. Significantly they have regularly found their way into practice for the enlightenment of the physician and the benefit of mankind. You are a credit to your training and an ornament to our profession.

Warmest personal regards.

Sincerely yours,

Bill

WILLIAM S. MIDDLETON, M.D.
Emeritus Dean, University of Wisconsin
Medical School

ARMAND J. QUICK *continued*

124. Prothrombin; physiology and deficient states, Am. Pract. & Dig. Treatment 3:397–402, May
125. Initiation of the clotting of blood, Proc. Soc. Exp. Biol. & Med. 80: 40–41, May (with C. V. Hussey)
126. Thromboplastic activity in human blood, J. App. Physiol. 4:840–847, May (with E. Epstein)
127. Newer knowledge concerning hemophilia, Chicago Med. Soc. Bull. May
128. Novo conceito sobre a coagulacao do sangue e as molestias hemorragicas, Resenha Clinico–Cientifica, 21:1–20, July
129. Abnormal bleeding in childhood, Postgrad. Med. 12:89–92, July
130. The action of Dicumarol in the human being on plasma prothrombin time and total prothrombin time, Am. Heart J. 44:119–123, July (with C. V. Hussey and M. Kaser)
131. The coagulation of blood and hemostasias, Seara Medica 7:83–90, July–December
132. The hemorrhagic diseases due to faulty coagulation, Seara Medica 7:91–100, July–December
133. Venous thrombosis, Seara Medica 7:101–110, July–December
134. The value and significance of blood clotting studies (editorial), Surg. Gynec. & Obst. 95:244–247, August
135. Problem of defective hemostasis in surgery, Am. J. Surg. 84:614–616, November
136. The influence of growth on vitamin K requirements, J. Pharmacol. & Exp. Therap. 106:411, December
137. The prothrombin in the newborn, Surg. Gynec. & Obst. 95: 671–676, December (with L. G. Murat, C. V. Hussey, and G. F. Burgess)
138. Clinical significance of defective clotting GP 4:43–50, December

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139. The pathological physiology of hemorrhagic conditions, Bull. New York Acad. Med. 29:226–234, March
140. Activation of thromboplastinogen by thrombin, Fed. Proc. 12: 222–223, March (with C. V. Hussey and E. Epstein)
141. Platelets; historical development, New York State J. Med. 53:541–542, March
142. Prothrombin activity of blood of the newborn, Proc. Soc. Exp. Biol. & Med. 82:449–450, March (with C. V. Hussey)
143. Hemophilia, Am. J. Med. 14:349–355, March
144. Interpretation of the one-stage method for determining prothrombin time, New Eng. J. Med. 248:624–628, April (with C. V. Hussey)
145. The prothrombin time; its role in the development of the modern concept of blood clotting, Marquette Med. Rev., 18:175–180, May
146. Hemophilic condition in a girl, A.M.A. Am. J. Dis. Child. 85: 698–705, June (with C. V. Hussey)
147. Newer concepts on the coagulation of the blood, Minnesota Med. 36:726–729, July
148. Effect of injecting platelet extract intravenously, Proc. Soc. Exp. Biol. & Med. 83:453–454, July (with E. Epstein)
149. Activation of thromboplastinogen by thrombin, Am. J. Physiol. 174: 123–126, July (with C. V. Hussey and E. Epstein)
150. Classification of the hypoprothrombinemias; based on the state of prothrombin in human blood, Am. J. Clin. Path. 23:951–964, October (with F. T. Flood and C. V. Hussey)
151. Hemophilic condition in the female, J. Lab. & Clin. Med. 42: 929–930, December (with C. V. Hussey)

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152. Vitamin K requirements of adult dogs and the influence of bile on its absorption from the intestine, Am. J. Physiol. 176:239–242, February (with C. V. Hussey and G. E. Collentine)
153. On the nature and diagnosis of hemophilia, Blood 9:265–272, March
154. Acquired antithromboplastinogenemia, Fed. Proc. 13:234, March (with C. V. Hussey)
155. The relation of coagulation of the blood to intravascular clotting, Schweiz. Med. Wchnschr. 84:783–785, July
156. Acquired antithromboplastinogenemia (hemophilia-like disease); with special reference to its diagnosis, J. Lab. & Clin. Med. 44: 94–103, July (with E. R. Daniels and C. V. Hussey)
157. The clotting activity of human erythrocytes; theoretical and clinical implications, Am. J. Med. Sci. 228:207–213, August (with J. G. Georgatsos and C. V. Hussey)
158. The chain reaction in the coagulation of blood; its theoretical and clinical significance, Sang 25:726–737
159. The effect of bile deprivation in the growing puppy, J. Lab. & Clin. Med. 44:909–910, December (with C. V. Hussey and G. E. Collentine)

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160. Congenital hypoprothrombinemic states, A.M.A. Arch. Int. Med. 95: 2–14, January (with A. V. Pisciotta and C. V. Hussey)

MARQUETTE UNIVERSITY SCHOOL OF MEDICINE

MILWAUKEE, WISCONSIN

Dear Harry:

It is a sincere pleasure for me to join in this presentation from the Wisconsin Medical Journal which has chosen to recognize the outstanding contributions you have made to the profession of medicine.

Our personal relationship has been especially satisfying to me and I have valued your sage counsel on numerous occasions. The fact that you did not volunteer your opinions to the solution of my problems as your successor to the chairmanship but always responded generously to my request for help may be the key reason why this transition proceeded so successfully. Our friendship has grown closer each year we have lived together in the department. Now that you have moved your offices to Columbia Hospital, I miss the ready opportunity to drop in and chat with you as we used to do. The other staff members also miss your presence in the department.

All of us have admired your vitality and the obvious satisfaction you gain from your professional work. Your dedication to your profession, integrity, generosity and wise leadership are attributes which will lead us in our efforts to continue the development and teaching of pharmacology at Marquette University. This is the program you started in 1926 and your name will always be associated with the achievements of the department.

Sincerely,

Harold F. Hardman

HAROLD F. HARDMAN
Professor and Chairman
Department of Pharmacology

161. A new method for measuring quantitatively the thromboplastinogen in plasma, Fed. Proc. 14: 265, March
162. Prothrombin and the one-stage prothrombin time, Brit. Med. J. 1:934–937, April (with C. V. Hussey)
163. Die-Ein-Stufen-Methode der Prothrombinzeit–Bestimmung, Deut. Mediz. Wchnschr. 80:620–621, April
164. Nature and action of a new clotting factor obtained from erythrocytes, Am. J. Physiol. 181:30–34, April (with J. G. Georgatsos and C. V. Hussey)
165. Hemorrhagic diseases of congenital origin, Postgrad. Med. 17: 382–387, May
166. The diagnostic approach in a hemorrhagic state, J. Iowa State Med. Soc. 45:321–323, July
167. On the denouement of the basic defect in hemophilia, Bull. Fac. Med. Istanbul 18:410–417 (Studia et Opuscula in Honorem Erich Frank)
168. Hemophilia and hemophiliacs, Bull. Med. Library Assn. 43:451–454, October
169. Le temps de consommation de la prothrombine en presence d'hemolysat. Son application au diagnostic et au traitment de l'hemophilie, Sang 26:633–649 (with P. Izard and C. V. Hussey)
170. Production of thrombin from precipitate obtained by acidification of diluted plasma, Am. J. Physiol. 183:114–118, October (with J. B. Perry and C. V. Hussey)
171. Erythrocytin, a new clotting factor from erythrocytes; its value in the study of hemophilia, J. Lab. & Clin. Med. 46:940, December (with C. V. Hussey)
172. Problems in blood coagulation (editorial), Am. J. Clin. Path. 25:285–287, December

1956

173. Newer knowledge of the common hereditary bleeding diseases, J. Iowa Med. Soc. 46:1–2, January
174. Comparative thromboplastin activity of acetone-dehydrated rabbit and human brain, Proc. Soc. Exp. Biol. & Med. 91:193–195, February (with C. V. Hussey and P. Izarn)
175. Hyperheparinemia observed clinically and after intravenous injection of papain into rabbits, Fed. Proc. 15:332, March
176. Hemophilia; quantitative studies of the coagulation defect, A.M.A. Arch. Int. Med. 97:524–531, May (with C. V. Hussey)
177. Diagnosis of hemophilia, Hemophilia and Hemophiloid Diseases, An International Symposium; K. M. Brinkhous, ed., University of North Carolina Press, Chapel Hill, August, pp. 169–173, 1957
178. Assay of normal and hemophilic blood for thromboplastinogen, Proc. Internat. Soc. Hematology, Boston, September, pp. 508–512
179. The effect of surface on various clotting constituents of the blood, Proc. VIth Congress Internat. Soc. Blood Transfusion, Boston, September; Biblioetheca Haematol. 7:341–345, 1958
180. On the probable mechanism of intravascular clotting, Angiology 7:419–426, October

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181. 'Erythrocytin' and 'erythrochelatin', Nature 179:54, Jan. 5
182. Congenital hypoprothrombinemia vera studied by the one-and two-stage prothrombin procedures, Fed. Proc. 16:235, March (with C. V. Hussey)
183. The thromboplastinogen activity time (TAT) test, Thromb. Diath. haem. 1:9–15, April
184. Hyperheparinemia; report of a case, Am. J. Med. Sci. 234:251–258, September (with C. V. Hussey)

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185. Synergistic action of Russell viper venom and tissue thromboplastin extracts, Proc. Soc. Exp. Biol. & Med. 97:674–676, March (with J. G. Georgatsos and C. V. Hussey)
186. Relation of bleeding time to coagulation of blood, Fed. Proc. 17;? March (with C. V. Hussey) Hussey)
187. Hereditary bleeding diseases. Med. Times 86:559–564, May

THE UNIVERSITY OF WISCONSIN

MADISON, WISCONSIN

Dear Dr. Beckman:

I appreciate the opportunity to participate in honoring you on the occasion of a special edition of the Wisconsin State Medical Journal.

Your many years of distinguished service as Chairman of Pharmacology at Marquette University and your outstanding teaching, scholarly publications and investigations are well known to all. Your success in these many endeavors has been a significant contribution to the field of pharmacology and medical practice.

May I extend my sincere congratulations and best wishes.

Cordially,

FRED HARVEY HARRINGTON
President

THE UNIVERSITY OF WISCONSIN

MADISON, WISCONSIN

Dear Dr. Quick:

I am privileged to have the opportunity to express the sentiments of the University of Wisconsin on this special occasion.

You have earned our highest respect for the outstanding research and inspired teaching which has characterized your life's work. Your contributions have enriched the field of medical science and benefited countless patients. Your achievements have brought credit to Wisconsin as an alumnus and to Marquette University as a distinguished faculty member.

May I extend my sincere congratulations and best wishes.

Cordially,

FRED HARVEY HARRINGTON
President

ARMAND J. QUICK *continued*

188. The problem of bleeding and its management as applied to surgery, obstetrics, and gynecology, Bull. North Shore Branch, Chicago Med. Soc. pp. 4–11, June
189. Haemophilia-like states in girls, Lancet 1: 1294–1298, June 21 (with C. V. Hussey)
190. On the factors underlying intravascular clotting, Surg. Clin North Amer., W. B. Saunders Company, August, pp. 1031–1043
191. Fundamental aspects of hemophilia, Acta haemat. 20:115–117, July–October
192. Action of erythrocyte extract on the prothrombin consumption test, Am. J. Physiol. 194:527–530, September (with F. Stanski)
193. The determinant of the prothrombin time in normal human plasma, Thromb. Diath. haem. 2: 226–235, September
194. Newer concepts of coagulation in relation to clinical practice, J. Nat. Med. A. 50:347–351, September
195. Biochemistry of clotting factors in tissues and erythrocytes, Pergamon Press, Proc. IVth Internat. Congress of Biochemistry, Vienna, September; Symposium X, *Blood Clotting Factors*, Ed., E. Deutsch 10:123–133, September 1959
196. Pseudohemophilias A and B, Symposium on Hemophilia, Rome, September; *Hemophilia and Other Hemorrhagic States*, Ed., K. M. Brinkhous, Chapel Hill, 1959 pp. 87–92
197. The nature of the clotting defect in hemophilia B (PTC deficiency or Christmas disease), Proc. VIIth Congress of Internat. Soc. Hematology, Rome, September; Il Pensiero Scientifico, Rome, 1959 pp. 190–194
198. Occult intravascular clotting, J. Lab. & Clin. Med. 52:935–936, December

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199. The development and use of the prothrombin tests, Circulation 19:92–96, January
200. Effect of injecting thrombin intravenously, Fed. Proc. 18: 305, March (with C. V. Hussey, J. Harris, and K. Peters)
201. Clotting compass, Thromb. Diath. haem. 3:302–310, April
202. The hereditary haemorrhagic diseases; their classification and diagnosis, Brit. Med. J. 1:1059–1062, Apr. 25
203. Hemophilia B (PTC deficiency or Christmas disease), A.M.A. Arch. Int. Med. 103:762–775, May (with C. V. Hussey)
204. The one-stage prothrombin time and the prothrombin consumption time, Electro Lyte 4:6–8, July
205. The physiologic protective mechanism against intravascular clotting, Angiology 10:386–390, October
206. Occult intravascular clotting by means of intravenous injection of thrombin, Am. J. Physiol. 197: 791–794, October (with C. V. Hussey, J. Harris, and K. Peters)
207. The coagulation mechanism; its application to hemophilia, Bull. Am. Assn. Blood Banks, 12:443–450, October
208. Hemolysate tests applied to the study of the Hageman trait, J. Lab. & Clin. Med. 54:935, December
209. Biochemistry in the medical curriculum (a faculty editorial), Marquette Med. Rev. 25:6–7, November

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210. Influence of acetylsalicylic acid and salicylamide on the coagulation of blood, J. Pharmacol. & Exper. Therap. 128:95–98, January (with L. Clesceri)
211. Influence of erythrocytes on the coagulation of blood, Am. J. Med. Sci. 239:51–60, January
212. Thromboplastinogenic defects of blood coagulation; a new test for their recognition, Fed. Proc. 19: 62, March
213. Erythrocyte extract (hemolysate) and tissue thromboplastin; their action on heparin activity, Proc. Soc. Exp. Biol. & Med. 103: 608–611, March (with M. E. Hickey)
214. Sporadic hemophilia, A.M.A. Arch. Int. Med. 106:335–340, September
215. Hemostasis; theoretic and clinical aspects, Plast. & Reconstr. Surg. 26:321–325, September
216. Current concepts of coagulation, Wisconsin Med. J. 59:647–649, October
217. The assay and properties of labile factor (factor V), J. Clin. Path. 13:457–462, November

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218. Hereditary labile factor (factor V) deficiency, J.A.M.A. 175:370–374, Feb. 4 (with I. A. Friedman, F. Higgins, C. V. Hussey, and M. E. Hickey)

DOCTOR BECKMAN'S bibliography and other recognitions appeared in the July issue.

UNIVERSITY OF MINNESOTA
COLLEGE OF VETERINARY MEDICINE

ST. PAUL, MINNESOTA

Dear Dr. Beckman:

I'm delighted to join in this expression of tribute, for it is not often that the opportunity comes to recognize a truly incomparable individual.

As a member of your department for nearly ten years, I witnessed an almost unbelievable combination of qualities and talents in the person of the chairman. It was an honor to be associated with a prolific and internationally known medical writer, who still found time for long hours of solitary work in the research laboratory. It was an inspiration to witness in action a concerned, dedicated and innovative teacher, for whom pharmacology was such fun that the students responded spontaneously with "Harry Beckman Day" at the end of the term. The department lunch table was a constant pleasure, sparked by the delightful mixture of good-natured joking and lively conversation ranging over history, the world of the arts, public affairs and, of course, baseball and fishing! Although you encouraged your staff to follow their own individual research interests, there was an esprit de corps in your department that I have yet to see equaled.

All honor to you, and may the challenges and rewards of the years to come surpass even those of years gone by!

Sincerely,

Grace Gray

GRACE W. GRAY, Ph.D.
Department of Veterinary
Physiology and Pharmacology

219. Labile factor (factor V) in serum, Fed. Proc. 20.56, March
220. Hemolysate prothrombin consumption time; a new test for thromboplastinogenic coagulation defects, J. Lab. & Clin. Med. 57: 290–299
221. Transfusions in the treatment of hemorrhagic diseases, Transfusion 1:99–110, March–April (with T. J. Greenwalt and C. V. Hussey)
222. Variations in the prothrombin complex of different species, Am. J. Physiol. 200:609–613, March (with R. Collins, F. Taketa, and C. V. Hussey)
223. Coagulation du sang et hémostase (editorial), Hemostase 1: 105–107, June
224. The theoretical basis and clinical application of the prothrombin time and prothrombin consumption time, Wisconsin Med. J. 60: 441–443, August
225. The diagnosis of common hereditary hemorrhagic diseases, Ann. Int. Med. 55:201–209, August
226. Hereditary bleeding diseases, J.A.M.A. 178:941–943, Dec. 2
227. Thromboplastic activity of red cells, Nature 192:882, Dec. 2
228. Comparison of the thrombotest with the one-stage prothrombin time, New Eng. J. Med. 265: 1286–1289, Dec. 28 (with C. V. Hussey)
229 Clinical interpretation of the one-stage prothrombin time, Circulation 24:1422–1428, December
230. The one-stage prothrombin time determination, its history and interpretation, Chemotherapia 3: 313–320
231. Thomboplastinogeno su evaluacion, aislamiento, funciones fisiologicas y utilidad terapeutica, Symposium Sobre Hemofilia held in Buenos Aires, August, 1959. Proceedings published by Academia Nacional de Medicina, Editor Dr. A. Pavlovsky, pp. 26–33
232. The one-stage prothrombin time, *Anticoagulants and Fibrinolysins*, an International Symposium held at Toronto, Canada, February 2, 3, and 4, published by The Macmillan Company of Toronto and edited by R. L. MacMilland and J. F. Mustard, pp. 177–186

1962

233. Hereditary hypoprothrombinaemias Lancet 1:173–177, Jan. 27 (with C. V. Hussey)
234. Probable metabolic relationship between factors VII and prothrombin, Fed. Proc. 21:59, March–April
235. Vitamin K requirements of the growing pup, J. Nutrition 77:28–32, May (with G. E. Collentine and C. V. Hussey)
236. Mechanism of blood coagulation, Southwestern Med. 43:285–291, July
237. Flavonoids in hemophilia, J.A.M.A. 181:41, July 7
238. Methods for clinical study of blood coagulation defects, *Progress in Coagulation*, Transactions of Conference of International Committee on Blood Clotting Factors, Wiesbaden, Germany, Sept. 3–6, 1961, I. S. Wright, F. Koller and E. Beck, editors, Friedrich–Karl Schattauer–Verlag, Stuttgart, 1962, pp. 307–313
239. Coagulation in retrospect (editorial), Am. J. Clin. Nutrition 10:177–179, September
240. Mild hemophilia A., probability of a variant, Am. J. Med. Sci., 244:535–547, November
241. The laboratory-clinical gap in hemorrhagic diseases (editorial–"Current Opinion"), Medical Tribune 3:15, Nov. 16

1963

242. Effect of warfarin, ethyl biscoumacetate, and phenindione on the factors of the prothrombin complex, J. Lab. & Clin. Med. 61: 302–307, February (with I. Noren)
243. Control of anticoagulant therapy; progress and problems, Arch. Int. Med. 111:234–239, February
243a. Role of platelets in prothrombin consumption, Fed. Proc. 22:504, March–April
244. The prothrombin consumption time test in thrombocytopenia, Thromb. diath. Haem. 9:113–119, April 15 (with M. Geppert)
245. Hereditary thrombopathic thrombocytopenia, Am. J. Med. Sci. 245:643–563, June (with C. V. Hussey)
246. Analgesia in hemophilia (editorial), Anesthesia and Analgesia 42:475–476, July–August
247. Co-existence of von Willebrand's disease and hemophilia in a family, J.A.M.A. 185:635–639, Aug. 24 (with R. T. Adlam)
248. Screening for bleeding states—the partial thromboplastin test, Am. J. Clin. Path. 40:465–472, November (with M. Geppert)
249. Anticoagulant action of adenosine triphosphate, Nature 200:469–470, Nov. 2
250. Prothrombin—analytical and clinical aspects; comparison of the one- and two-stage methods, Am. J. Med. Sci. 246–517–526, November (with C. V. Hussey and M. Geppert)
251. Antivivisection (faculty editorial), Marquette Med. Rev. 29: 151–153, November

1964

252. Platelets, erythrocytin and tissue thromboplastin, New Istabul Contrihution to Clinical Science 7: 156–163, January–April
253. Anticoagulant action of adenosine di- and triphosphate (ADP and ATP), Fed. Proc. 23:299, March–April
254. Research association between student and teacher, Marquette Med. Rev. 30:90–95, May
255. Symposium—Use of Anticoagulants; pro and con, Postgrad. Med. 35:629–637, June (presented before the 48th Annual Assembly of the Interstate Postgraduate Medical Association, Chicago,

MILWAUKEE COUNTY

MILWAUKEE, WISCONSIN

Dear Dr. Beckman and Dr. Quick:

Both personally and as County Executive of Milwaukee County, I am pleased to join with your many friends, admirers, and professional colleagues in paying tribute to you for your years of selfless devotion to the betterment of the health of your fellowman.

You have particularly distinguished yourselves in the fields of pharmacology and biochemistry, respectively; and, as professors and directors of those respective departments in the Marquette University School of Medicine for many years, you have contributed immeasurably to the knowledge and skills of innumerable fellow members of your profession.

We in Milwaukee County are deeply grateful to both of you and thank you sincerely for the many benefits which have accrued to all of us through your great talent and untiring efforts.

With every good wish to both of you, and with kindest personal regards, I remain

Yours very truly,

JOHN L. DOYNE
County Executive

November 1963 with Alton Ochsner, Oglesby Paul and Ormand C. Julian)

256. The interpretation of hemostatic tests in unexplained bleeding, Ann. New York Acad. Sci. 115:252–259, July 9 (presented at the Conference on Bleeding in the Surgical Patient, New York, May 1963)
257. Quality control in Coagulation, Hospital Progress, 8:130–144, August (presented at the Workshop on Quality, Quality Control and Automation for the Catholic Hospital Association, Chicago, November 1963)
258. The Coagulation of Blood, The Filter 36:157–158, December (presented at the 25th Anniversary Convention of the California Association of Medical Laboratory Technologists, Fresno, California, October)
259. The physician's approach to the hemophiliac, *International Symposium on The Hemophilias*, held at Washington, D. C. December 1963. Editor, K. M. Brinkhous, University of North Carolina Press,, pp. 380–384

1965

260. One-stage prothrombin time in the control of anticoagulant therapy, *Anticoagulant Therapy in Ischemic Heart Disease*, An International Symposium sponsored by the Miami Heart Institute January 9–11, 1964, E. Sterling Nichol, editor, 1965, pp. 381–388
261. Prothrombin consumption time in deficiencies of factors VII, IX and X, Fed. Proc. 24:453, 1965
262. Hemorrhage in the newborn, Journal Lancet 85:222–225, June
263. Hereditary thrombopathic thrombocytopenia and Minot-von Willebrand syndrome; probable coexistence in a family, Am. J. Med. Sci. 250:1–7, July
264. Mild bleeding; a credible complaint, Consultant 5:8–11, October
265. Hereditary thrombopathic thrombocytopenia; sex-linked inheritance pattern, Am. J. Med. Sci. 250:527–531, November

1966

266. Von Willebrand's disease and hemophilia in a family; clinical comparison, Clin. Med. 73:17–22, January
267. The prothrombin consumption time test, Am. J. Clin. Path. 45: 105–109, January
268. Thrombopathy – thrombasthenia, Am. J. Med. Sci. 251: 156–160, February
269. Effect of aspirin on the bleeding time, Fed. Proc. 25:498, March–April
270. Emergencies in hemophilia, Am. J. Med. Sci. 251:409–416, April
271. Menstruation in hereditary bleeding disorders, Obst. & Gynec. 28: 37–48, July
272. Current blood clotting schemes, Thromb. Diath. haem. 16:318–330, July
273. Detection and diagnosis of hemorrhagic states, J.A.M.A. 197: 418–420, Aug. 8
274. Morals and the medical scientist, Linacre Quart. 33:274–276, August
275. Salicylates and bleeding; the aspirin tolerance test, Am. J. Med. Sci. 252:265–269, September
276. Acetylsalicylic acid and haemorrhage, Lancet 2:1134, Nov. 19
277. Minot–von Willebrand syndrome, J. Lab. & Clin. Med. 68:1008, December (Cent. Soc. Cl. Res., Abstr. 112)

1967

278. Aspirin and platelet stickiness, Lancet 1:386, Feb. 18
279. Thromboplastin generation test (laboratory procedures, their clinical significance), J.A.M.A. 199: 659, Feb. 27
280. Acetylsalicylic acid in haemophilia, Brit. Med. 1:424, Feb. 18
281. Nature of the hematotoxic action of acetylsalicylic acid, Feb. Proc. 26:(abstr. 2803), March–April

UNIVERSITY OF WISCONSIN MEDICAL CENTER

MADISON, WISCONSIN

Dear Doctor Beckman:

The honor which the *Journal* editorial staff and the State Medical Society confer upon you in this issue gives me the opportunity to express my admiration of you and the distinguished career you have brought as a scientific investigator and teacher of pharmacology and therapeutics and for the contribution you have made to postgraduate medical education. Best Wishes.

Sincerely,

W. D. Stovall

W. D. STOVALL, M.D.
Special Assistant to the Dean

DETOXICATION, CONJUGATION AND LIVER FUNCTION

1920

1. The preparation of -phenylenediamine and aniline from their corresponding chlorobenzenes, J. Am. Chem. Soc. 42:1033–1042, May
2. The properties of subsidiary valence groups. I. The molecular volume relationships of the hydrates and ammines of some cobalt compounds. II. Subsidiary group mobility as studied by the heat decomposition of some cobalt-ammines, J. Am. Chem. Soc. 42:2483–2498, December (with G. L. Clark and W. D. Harkins)

1922

3. Aliphatic arsonic and arsinic acids and aliphatic–aromatic arsinic acids, J. Am. Chem. Soc. 44:805–816, April (with Roger Adams) (thesis for doctorate)

1923

4. The estimation of albumin in urine, J. Lab & Clin. Med. 8:1–4, June

1924

5. A method for the quantitative determination of menthol glycuronic acid in urine, J. Biol. Chem. 61:667–677, October
6. The synthesis of menthol glycuronic acid in the rabbit, J. Biol. Chem. 61:679–683, October

1925

7. Effect of sodium carbonate concentration in the Benedict sugar method, Ind. & Eng. Chem. 17: 729–732, July

1926

8. The study of benzoic acid conjugation in the dog with a direct quantitative method for hippuric acid, J. Biol. Chem. 67: 477–490, February
9. The preparation and study of -glycuronic acid monobenzoate (benzoly glycuronic acid), J. Biol. Chem. 69:549–563, August
10. The production of conjugated glycuronic acids in depancreatized dogs, J. Biol. Chem. 70:59–69, September
11. On the origin of glycuronic acid in the organism, J. Biol. Chem. 70:397–404, October

1927

12. The preparation of borneol glycuronic acid and glycuroni acid, J. Biol. Chem. 74:331–341, August

1928

13. Quantitative studies of -oxidation. I. The conjugation of benzoic acid and phenylacetic acid formed as the end-products from the oxidation of phenyl-substituted aliphatic acids, J. Biol. Chem. 77:581–593, May
14. Quantitative studies of -oxidation. II. The metabolism of phenylvaleric acid, phenyl- ,-pentenic acid, phenyl- , -pentenic acid, mandelic acid, phenyl- -hydroxypropionic acid, and acetophenone in dogs, J. Biol. Chem. 80:515–526, December
15. Quantitative studies of -oxidation. III. The fate of phenylbutric acid in depancreatized dogs,

J. Biol. Chem. 80:527–534, December (with J. W. Sweet)
16. Quantitative studies of -oxidation. IV. The metabolism of conjugated glycuronic acids, J. Biol. Chem. 80:535–541, December

1929

17. The fermentation of glycuronic acid by certain bacteria, J. Bact. 18:133–137, August (with M. C. Kahn)

1931

18. Hyperparathyroidism; the clinical picture in the far advanced stage, J.A.M.A. 96:745–751, Mar. 7 (with A. Hunsberger, Jr.)
19. The conjugation of benzoic acid in man, J. Biol. Chem. 92:65–85, June

1932

20. Influence of ortho substitution on the conjugation of benzoic acid, Proc. Soc. Exp. Biol. & Med. 29:509–510, January
21. On the chemistry of the conjugation of benzoic acid, J. Biol. Chem. 95:189–196, February
22. The site of the synthesis of hippuric acid and phenylaceturic acid in the dog, J. Biol. Chem. 96:73–81, April
23. Conjugation of benzoic acid with glycine, a test of liver function, Proc. Soc. Exp. Biol. & Med. 29: 1204–1205, June
24. The relationship between chemical structure and physiological response. 1. The conjugation of substituted benzoic acids, J. Biol. Chem. 96:83–101, April
25. Conjugation of hydroxy benzoic acids in dog and in man, J. Biol. Chem. 97:lxix, July
26. The relationship between chemical structure and physiological response. II. The conjugation of hydroxy- and methoxybenzoic acids, J. Biol. Chem. 97:403–419, August
27. The relationship between chemical structure and physiological response. III. Factors influencing the excretion of uric acid, J. Biol. Chem. 98:157–169, October
28. Quantitative studies of -oxidation. V. The effect of insulin and of acetoacetic acid on the production of glycuronic acid, J. Biol. Chem. 98:537–541, November
29. The effect of liver injury on the conjugation of benzoic acid in the dog, J. Biol. Chem. 99:119–124, December (with M. A. Cooper)

1933

30. New reagent for determination of zinc, Ind. & Eng. Chem. 5:26–27, January; a continuous extractor, ibid, p. 76
31. Hypertrophy of adrenals in scurvy, Proc. Soc. Exp. Biol. & Med. 30:753–754, March
32. The production of glucuronic acid in scurvy, J. Biol. Chem. 100: 441–444, April
33. The synthesis of hippuric acid; a new test of liver function, Am. J. Med. Sci., 185:630–635, May
34. The relationship between chemical structure and physiological response. IV. Conjugation of salicylic acid with glycine and its action on uric acid excretion, J. Biol. Chem. 101:475–485, July

1934

35. The probable allergic nature of cinchophen poisoning; with special reference to the Arthus phenomenon and with precautions to be followed in cinchophen administration, Am. J. Med. Sci. 187:115–121, January
36. A new concept of the significance of uric acid in clinical medicine. Med. Clin. North America 17: 1325–1337, March
37. Relationship of uric acid excretion to ketosis, lactic acid metabolism and aromatic acids, J. Biol. Chem. 105:LXIX–LXX, May
38. A note on the structure and chemistry of glucuronic acid monobenzoate, Biochem. J. 28, 403–405

1935

39. The effect of exercise on the excretion of uric acid; with a note on the influence of benzoic acid on uric acid elimination in liver diseases, J. Biol. Chem. 110:107–112, June
40. Hyperparathyroidism: Clinical picture in the far advanced stage; second report, J.A.M.A. 104:2248–2249, June 22 (with A. Hunsberger, Jr., E. L. Eliason, and H. Hudson)

1936

41. Clinical value of the test for hippuric acid in cases of disease of the liver, Arch. Int. Med. 57:544–556, March

1938

42. Synthesis of hippuric acid in man following intravenous injection of sodium benzoate, Proc. Soc. Exp. Biol. & Med. 38:77–78, February (with H. N. Ottenstein and H. Weltchek)

1939

43. Intravenous modification of the hippuric acid test for liver function, Am. J. Dig. Dis. 6:716–717, December

1940

44. The hippuric acid test as a means for determining hepatic function, Acta med. Scand. 104:216–220

1942

45. Excretion rate of hippuric acid in man, Proc. Soc. Exp. Biol. & Med. 50:319–320, June

1944

46. The clinical value of liver function tests; with particular reference to the hippuric acid test, Wisconsin Med. J. 43:399–404, April
47. Functional changes of the liver after experimental injury. A note on the dog's tolerance for glycine, Exp. Med. & Surg. 2:298–303, November (with E. C. Loomis)

1945

48. An appraisal of the hippuric acid test after twelve years of clinical trial, Marquette Med. Rev. 10:63–74, March

1947

49. Pancreatic and liver function, Northwest Med. 46:762–764, October

1948

50. Hippuric acid liver function test, Clin. Med. 55:106–107, April

UNIVERSITY OF WISCONSIN MEDICAL CENTER

MADISON, WISCONSIN

Dear Doctor Quick:

Through the years at State Medical Society meetings, sometimes in your laboratory, and often at casual meetings, we have joined in friendly discussion and I have listened to you lecture on blood coagulation and the description of texts by which you accumulated knowledge concerning this phenomenon.

Your cordial and warm personality made these meetings pleasantly informal and left a lasting memory.

You have created a distinguished career by your researches in biologic science, and as a teacher your students held you in high regard and devotion. Throughout the nation and the world, tests which you devised and described are wherever scientific medicine is practiced.

It is a pleasure to have the opportunity to greet you, congratulate you upon a distinguished career, and to extend my best wishes for continued good health and happiness.

Sincerely,

W. D. Stovall

W. D. STOVALL, M.D.
Special Assistant to the Dean

ARMAND J. QUICK *continued*

COMMENTS ON TREATMENT

Wisconsin Medical Journal

1938

1. Sulfanilamide, 37:560, July
2. Hiccup, 37:824, September
3. Apomorphine, 37:916, October
4. Spasmodic rectal pain, 37:917, October
5. Simple nocturnal enuresis, 37:1013, November

1939

6. Antacids, 38:35, January
7. Vitamin K in jaundice, 38:209, March
8. Stored blood in transfusion 38:647, August
9. Hemorrhagic disease of the newborn, 38:746, September

1940

10. Plasma transfusion, 39:35, January
11. Pinworm (oxyuris vermicularis), 39:532, July
12. Carbon monoxide poisoning, 39:611, August
13. A classification of drug toxicity I, 39:947, November

1941

14. A classification of drug toxicity II, 40:31, January
15. Prevention of bleeding in the newborn, 40:581, July
16. Treatment of acute bacillary dysentery with sulfanyl-guanidine, 40:1064, November

1942

17. Frostbite and allied conditions, 41:46, January
18. Chloral hydrate, 41:123, February
19. Intrabone marrow infusion, 41:223, March
20. Trichlorethylene, 41:490, June
21. On the detection of potential pulmonary embolism and its prophylaxis, 41:587, July
22. Fever and the antipyretic drugs, 41:780, September
23. The Miller–Abbott tube (with Dr. C. R. Olson), 41:915, October
24. Vitamins in health and disease, 41:1016, November
25. Papaverine in heart disease, 41:1108, December

1943

26. Plasma in severe burns, 42:229, February
27. Painful shoulder syndrome, 42:418, April
28. Estrogens in premature infants, 42:608, June
29. Swimmer's itch, 42:705, July

1944

30. Demoral, 43:326, March
31. Drugs and hemorrhage 43:426, April
32. Thioracil in hyperthyroidism, 43:537, May

1945

33. Ophthalmia neonatorum, 44:226, February
34. Toxic action of morphine, 44:310, March
35. Rheumatic fever I, 44:422, April
36. Rheumatic fever II, 44:522, May

CHAPTERS, BOOK REVIEWS, OTHER CONTRIBUTIONS

1937

Detoxication Mechanisms, *Annual Review of Biochemistry*, Stanford University 6:291–303

Putrefaction and Detoxication (chapter XX), *Practical Physiological Chemistry*, Hawk & Bergeim, Blakiston, Philadelphia, 11th edition, pp. 355–366

1943

Chemothrapy; Detoxication; Pharmacology; Toxicology, *Dictionary of Biochemistry and Related Subjects*, Philosophical Library, Inc., New York, Editor, W. M. Malisoff; pp. 133–135, 173–175, 400–402, 535–537

1944

Blood, *Annual Review of Physiology* 6:295–318

The Anticoagulants Effective in Vivo with Special Reference to Heparin and Dicumarol, *Physiological Reviews* 24:297–318

Relation of Amino Acids to Biologically Important Products and the Role of Certain Amino Acids in Detoxication (chapter VIII), Sahyun's *Outline of Amino Acids and Proteins*, Reinhold Publishing Company, New York, pp. 158–178

1946

Vitamin K, Tice's *Practice of Medicine* 1:503–522

Theories of Blood Coagulation, *Cyclopedia of Medicine, Surgery and Specialties* 2:387–392

1947

Putrefaction and Detoxication (chapter XX), *Practical Physiological Chemistry*, Hawk, Oser and Summerson, ibid, 12th edition pp. 387–398

1948

Relation of Amino Acids to Biologically Important Products and The Role of Certain Amino Acids in Detoxication (chapter VIII) Sahyun's *Outline of Amino Acids and Proteins*, ibid, pp. 158–178

Book Review—Hemostatic Agents: With particular reference to thrombin, fibrinogen, and adsorbable cellulose, by W. H. Seegers and E. A. Sharp, Charles C. Thomas, Springfield

1950

The Coagulation of Blood and Hemostasis, *Annual Review of Physiology* 12:237–264

1952

Blood Coagulation: Theory of A. J. Quick, *Standard Values in Blood*, Division of Biology, National Research Council, p. 12

1954

Putrefaction, Detoxication and Conjugation (chapter XX), *Practical Physiological Chemistry*, ibid, 13th edition, pp. 436–445

Blood, Lymph, and Cerebrospinal Fluid (chapter XXII), (a revision), *Practical Physiological Chemistry*, ibid, 13th edition, pp. 456–496

Pharmacologic Agents Affecting the Clotting Time of Blood (chapter 44), *Pharmacological Principles of Medical Practice*. Williams & Wilkins by

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VETERANS ADMINISTRATION CENTER

WOOD, WISCONSIN

Dear Dr. Quick:

I am grateful for the privilege of adding my greeting to you in this special issue of the Wisconsin Medical Journal. For many years of association with you, I have enjoyed your friendship and that of Mrs. Quick, and I recall the pleasure of being included in small seminars and other gatherings in your home.

Accustomed to working in environments where active research was being carried on, I have appreciated and recognized my good fortune in my affiliation with an outstanding scientist, who found joy in his research and in the rewards of discovery. In these days of large research teams and institutions, we have tended to forget that initial inspiration and sound progress in science originate in the mind of the investigator. You are one of those few to whom scientific productivity and integrity have been of great importance, pleasure and pride. May these satisfactions continue in your years of retirement.

Sincerely,

Margaret M Kaser

MARGARET M. KASER, Ph.D.
Chief, Clinical Chemistry Section

J. C. Krantz, Jr. and C. J. Carr, 3rd edition, pp. 873–894

1955

Book Review—Standard Values in Nutrition and Metabolism, by E. C. Albritton, George Washington University, W. B. Saunders, 1954

1957

Agents Affecting Blood Formation and Coagulation (chapter 9), *New and Nonofficial Remedies*, J. P. Lippincott Company, Philadelphia, pp. 256–269

Contributor to: Revision of *Dorland's Illustrated Medical Dictionary*, 23rd edition

Book—Hemorrhagic Diseases, Lea & Febiger, Philadelphia, April

1958

Hemophilia: Method of Armand J. Quick, M.D., *Current Therapy:* A compendium of the latest approved methods of treatment for the practicing physician. Editor: H. F. Conn. W. B. Saunders, pp. 207–209

Pharmacologic Agents Affecting the Clotting Time of Blood (chapter 44), *Pharmacological Principles of Medical Practice*, ibid, 4th edition, pp. 954–979

Book Review—Antikoagulantien by Prof. Dr. Eberhard Perlick, VEB George Thieme, Hainstr. 17/19, Aufg. C. 1, 1957 (Arch. Int. Med. 101:1009, May)

1959

Coagulation of the Blood (chapter 11), *Encyclopedia of Cardiology* 4:275–282

Prothrombin—Thrombin Relationships, *Intravascular Phenomena*. Proc. of 7th Conference on Microcirculatory Physiology and Pathology, National Institutes of Health, Bethesda, Md. (May 4, 5, 1959), edited by E. P. Fowler, Jr. and B. W. Zweifach, pp. 48–65

1961

Vitamin K Antagonists. (Supplement to: Vitamin K) Tice's *Practice of Medicine* 1:522a–522i

Pharmacologic Agents Affecting the Clotting Time of Blood (chapter 44), *Pharmacological Principles of Medical Practice*, ibid, 5th edition, pp. 1069–1101

Blood Coagulation Theories: Clotting Scheme, Clotting time, and Summary of Normal Test Values (chapter XI), Blood and Other Body Fluids, Biological Handbook, Federation of American Societies for Experimental Biology by Philip L. Altman and D. S. Dittmer, pp. 234, 240 and 244

1963

Anticoagulants in the Aging, *Clinical Principles and Drugs in the Aging*, Edited by Joseph T. Freeman, M.D. Charles C. Thomas, Springfield, Chapter 22, pp. 411–420

1965

Pharmacologic Agents Affecting the Clotting Time of Blood (chapter 44), *Pharmacologic Principles of Medical Practice*, ibid, sixth edition, pp. 695–714

Coagulation of the Blood (chapter 11, section 2), *Examination of the Cardiac Patient* (formerly *Encyclopedia of Cardiology*), Edited by Aldo A. Luisada, McGraw-Hill, New York, 1965, pp. 4–275 to 282

Blood Coagulation (chapter 12, Blood and Other Body Fluids), *Hawk's Physiological Chemistry*, 14th edition, edited by Bernard L. Oser, McGraw-Hill, New York, 1965, pp. 343–348 and 361–363)

Preface—to Biologie des Hemorragies et des Thromboses by C. Raby, Masson & Cie, Paris

Contributor to: New Drugs: Evaluated by A.M.A. Council on Drugs, 1965 A.M.A., Chicago

1966

Book. Hemorrhagic Diseases and Thrombosis, Lea & Febiger, Philadelphia, July, second edition

1959: Council Award—Dr. Harry Beckman

DR. HARRY BECKMAN (left) is shown in 1959 when he received the Council Award from Dr. James C. Fox of La Crosse, chairman of the Council of the State Medical Society of Wisconsin.

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Reprinted from the *Milwaukee Journal*, May 16, 1954. By James C. Spaulding

Flops as gear shifter but is tops in research

DR. ARMAND J. QUICK of Marquette university is the sort of scientist who starts working the moment his feet touch the floor in the morning. He has been known to plan a series of experiments that will take months to complete while riding a bus to his laboratory.

Yet he is not as oblivious to the world as his colleagues often suspect. He is a student, particularly of history, and has been known to pound the breakfast table while arguing about politics. And he is intensely interested in human beings as well as in how their blood coagulates.

Dr. Quick's concentration is renown. He is generally regarded as the champion of the medical school faculty for driving a car the longest distance in second gear without noticing it.

Leader in Research

This concentration and his sustained enthusiasm for work have helped him become one of the world's foremost research scientists in hemorrhagic diseases.

MILWAUKEE JOURNAL Photo

DR. ARMAND J. QUICK (third from left) is shown with some of his Marquette University associates who were viewing one of the rare books on the history of medicine in the new Eben J. and Helene M. Carey Memorial Library which was dedicated in 1954. The photo, which appeared in the May 16, 1954, edition of the Milwaukee Journal, *shows, from left, Drs. Donald A. Roth, Michael Laskowski, Quick, P. F. Swindle, G. Kasten Tallmadge, and Vaughan Simmons.*

For his scientific attainments, Dr. Quick is being honored Friday and Saturday at an international conference here on hemorrhagic diseases. The conference is part of the dedication program of the new medical school library addition of Marquette university.

Test Is Used Often

. . . Probably Dr. Quick is best known for developing the prothrombin time test, commonly called the "Quick test." It is used thousands of times daily in hospitals throughout the world to determine accurately the clotting ability of patients' blood.

The Quick test made it possible for the first time to study hemorrhagic diseases in detail. The test also led to development of drugs that have saved lives in several diseases.

Dr. Quick himself, with coworkers, has done much of the exploring in hemorrhagic diseases. . . .

Besides the honors and respects won in his profession, Dr. Quick has earned a loyalty amounting to devotion from the people he has helped.

Dr. Quick is not in clinical practice, but physicians all over the United States send him patients for diagnosis. Many are treated at Milwaukee Children's hospital. . . .

Dr. Quick often becomes strongly attached to his patients, many of whom are children. He admits that this "failing" would make clinical practice, where detachment is desirable, a difficult field for him.

One such attachment developed when William Stapp, now a physician practicing pathology at Dallas, Tex., came to the Marquette medical school to study.

Suffers from Hemophilia

Dr. Stapp himself suffers from severe hemophilia. He came to Marquette because he hoped that by being near Dr. Quick, he could get help. . . .

Dr. Stapp's wish came true. He became Dr. Quick's assistant, coworker and friend. Dr. Quick treated him like an only son and on occasion would stay with him most of the night when Dr. Stapp got into trouble with his disease. . . .

The Quick test proved to be a valuable tool in helping Dr. Karl Paul Link of the University of Wisconsin isolate dicumarol from spoiled sweet clover. Dicumarol is a valuable anticlotting drug. Its use depends on the Quick test for proper control.

Other discoveries have followed. Dr. Quick discovered that blood stored at low temperature loses its ability to clot because of a "labile" factor. He predicted a patient would be found who lacked this factor.

Less than two years later, Dr. P. A. Owren at Oslo, Norway, reported treating such a patient.

Dr. Quick developed his prothrombin consumption test in 1947. . . .

In all this work, Dr. Quick gives much credit to the men and women who have worked with him. They include Miss Clara Hussey, a biochemistry instructor at Marquette; Dr. George Collentine, Jr., director of postgraduate programs at the Marquette medical school, and students and former students such as Dr. Stapp, Dr. Ivan Baronofsky of Minneapolis, Minn., and Ernest Epstein of Marshfield, Wis.

Come from Foreign Countries

Some have come from foreign countries to study and work with Dr. Quick. Among them are Dr. Luiz Gonzaga Murat of Sao Paulo, Brazil; Dr. Mario Stefanini, formerly of Italy and now at Yale university; Dr. Jean Favre-Gilly of Lyons, France, and Dr. John Georgatsos of Salonika, Greece.

To get blood for research, Dr. Quick has been tapping himself several times a week for the 20 years he has been at Marquette.

This was not enough, however, and medical students used to detour Dr. Quick's laboratory. He had a habit of darting out of his office to enlist "volunteer" donors.

Uses Animals in Test

Dr. Quick has used animals in much of his research and makes friends with them as he does his patients. One mongrel, "Midnight," became so fond of him that he would jump up on the experiment

MILWAUKEE JOURNAL Photo

A 1954 FEATURE IN THE Milwaukee Journal *included a photo of Dr. Armand J. Quick (left) discussing some laboratory equipment with Chase W. Wolfe, Jr., a student, and Miss Clara Hussey, an instructor.*

Distinguished Service Award

FOR RESEARCH IN MEDICAL SCIENCE

May 12, 1964

ARMAND J. QUICK, M.D., Ph.D., is honored by this Award of the State Medical Society of Wisconsin for his outstanding contributions to the science and art of medicine, through his 30 years of teaching at Marquette University School of Medicine and for his distinguished work in unveiling the complex physiology of blood coagulation and revealing its clinical application through the familiarly-known "Quick Test."

Physicians revere Doctor Quick for his inquisitive mind, his warm personality as a teacher, his writings in subjects of medical science, and his enthusiasm in probing the unknown in his chosen field of biochemistry.

(Reproduced from the original plaque)

table and obligingly turn his head so Dr. Quick could slip the needle in for a blood sample.

Dr. Quick was a leader in the fight in Wisconsin against antivivisectionists. He helped get a law passed permitting medical schools to obtain animals for research from pounds.

Dr. Quick demands hard work from his assistants, and gets it. He himself is an insatiable worker. Even while listening to opera broadcasts on Saturday afternoon, which he seldom misses, he stays at his desk and works. . . .

With all the honors he has received, Dr. Quick is still a modest man. Much of his success, he says, can be attributed to getting into the right field at the right time.

Now and then he realizes he does not, perhaps, fit the conventional picture of success. For example, he becomes attached to things, as well as to persons. For about 12 years he was so fond of a low priced automobile that he could not bear to part with it.

"I suppose," he commented when someone remarked about the car, "people think I don't amount to much."

* * *

Doctor Quick, now emeritus professor of biochemistry at Marquette University, still works in the school's laboratory and acts as consultant to eight Milwaukee hospitals.

CURRICULUM VITAE . . . Armand J. Quick, M.D.

Professor Emeritus of Biochemistry, Marquette University School of Medicine, Milwaukee, Wisconsin

BIRTHPLACE: Theresa, Wisconsin
BIRTHDATE: July 18, 1894
MARRIED: July 2, 1937

EDUCATION

1914		Central High School, Madison
1918	B.S.	University of Wisconsin (Chemistry)
1919	M.S.	University of Wisconsin (Chemistry)*
1922	Ph.D.	University of Illinois (Organic Chemistry)**
1928	M.D.	Cornell University

EXPERIENCE

1918–1919	Assistant in Chemistry, University of Wisconsin
1919–1920	Instructor in Chemistry, Vanderbilt University
1920–1921	Fellowship in Chemistry, University of Illinois
1921–1922	Assistant Chemist, Philadelphia General Hospital
1922-1926	Instructor in Physiological Chemistry, University of Pennsylvania Medical School
1926–1928	Assistant in Research Surgery, Cornell University Medical College
1928–1930	Intern, Philadelphia General Hospital
1930–1932	Associate in Research Surgery, Cornell University Medical College Assistant Physician, Cornell Clinic
1932–1934	Fellow in Research Surgery, Fifth Avenue Hospital, New York (One-stage prothrombin time developed here)
1935–1937	Assistant Professor of Pharmacology, Marquette University School of Medicine
1937–1944	Associate Professor of Pharmacology, Marquette
1944–1964	Professor of Biochemistry and Director of Department, Marquette
1964	Professor Emeritus of Biochemistry, Marquette

RESEARCH FIELDS

Detoxication mechanisms and liver function
Blood coagulation
Hemorrhagic diseases
Thrombosis and oral anticoagulant therapy
Role of clot retraction in phlebothrombosis
Development of hippuric acid test
Development of one-stage prothrombin time
Development of prothrombin consumption time
Discovery of congenital hypoprothrombinemia
Discovery of labile factor

MEMBERSHIPS

American Association for the Advancement of Science (1940)
American Society of Pharmacology and Experimental Therapeutics (1935)
American Society of Biological Chemists (1932)
American Chemical Society (1918)
Central Society for Clinical Research (1938)
Society of Experimental Biology and Medicine (1930)
Sigma Xi
American Heart Association—Wisconsin Heart Association
American Medical Association—Wisconsin State and Milwaukee County Societies
Milwaukee Internist Society (1938)
American InterProfessional Institute, Milwaukee Chapter*
Chemists' Circle
Phi Beta Kappa (1917)
Phi Beta Pi
Phi Lamda Upsilon
Alpha Omega Alpha

HONORARY MEMBERSHIPS

Tacoma (Washington) Surgical Club (1947)
New Mexico Clinical Society (1949)
Sociedad Chilena de Transfusion y Hematologica (1951)
Sociedad Medica de Santiago (1951)
Sociedad Medica de Concepcion (1951)
Sociedad de Biologia de Santiago de Chile (1951)
Sociedad de Biologia de Concepcion (1951)
Facultad de Biologia y Ciencias Medicas, Universite de Chile (1951)
Facultad de Biologia y Ciencias Medicas, Universite de Concepcion (1951)
Milwaukee Academy of Medicine (1959)
Omicron Kappa Upsilon (Honorary dental society, 1961)

RELATED ACTIVITIES

International Committee for the Nomenclature of Blood Clotting Factors, Emeritus member
International Haemophilia Society, London, a Vice-president
National Hemophilia Foundation, New York, Medical Advisory Council member
Midwest Chapter of National Hemophilia Foundation, Chicago, Medical Advisory Council chairman* and member*
Wisconsin Chapter of National Hemophilia Foundation, Milwaukee, Medical Advisory Council member
European Society of Haematology, corresponding member
Société Suisse d'Hématologie, corresponding member (1964)
National Board of Medical Examiners, Division of Biochemistry (1954–1958)
Wisconsin Society for Medical Research, Inc., member of Board of Directors
Research Committee member:
- Milwaukee Children's Hospital
- Milwaukee Blood Center, Inc.
- Milwaukee County Medical Society (Blood and Blood Substitutes and Tissue Bank Committees)*

Marquette University School of Medicine Executive Faculty*
Marquette Medical School Glee Club, moderator*, and Alpha Kappa Kappa
Marquette Medical Review, Advisory Board member
Editorial Board Member:
- Hemostáse, Paris (Scientific Committee)
- Nouvelle Revue Française D'Hematologie, Paris (Scientific Council)
- American Heart Journal
- JAMA (Consultant)
- Journal of Laboratory and Clinical Medicine
- Journal of Pharmacology and Experimental Therapeutics
- Thrombosis et Diathesis Haemorrhagica
- Transfusion (Consulting editor)

* Previously.

HOSPITAL AFFILIATIONS

Milwaukee Children's Hospital, Attending Staff
Milwaukee County Hospital, Honorary Staff
St. Mary's Hospital, Honorary Staff
Columbia Hospital, Consulting Staff
Deaconess Hospital, Consulting Staff
Mount Sinai Hospital, Consulting Staff
St. Anthony's Hospital, Consulting Staff
St. Luke's Hospital, Consulting Staff

VISITING PHYSICIANS

Chile	Italy	Poland
Brazil	Sweden	Germany
France	Greece	South Africa

PUBLICATIONS

Over 300 papers and four monographs:
- The Hemorrhagic Diseases and The Physiology of Hemostasis, Charles C. Thomas, Springfield, Illinois, 1942
- The Physiology and Pathology Hemostasis, Lea & Febiger, Philadelphia, 1951
- Hemorrhagic Diseases, Ibid, 1957
- Hemorrhagic Diseases and Thrombosis, Ibid, 1966

CONTRIBUTED TO

Annual Review of Biochemistry (1937)
Annual Review of Physiology (1944, 1950)
Clinical Principles and Drugs in the Aging (1963)
Comments on Treatment, Wisconsin Medical Journal (1938–1945)
Current Therapy (1958)
Cyclopedia of Medicine, Surgery, Specialties (1946)
Dictionary of Biochemistry and Related Subjects (1943)
Dorland's Illustrated Medical Dictionary, 23rd edition (1957)
Encyclopedia of Cardiology (1959)
Examination of the Cardiac Patient (formerly Encycl. Cardiol.) (1965)
Handbook of Nutrition, AMA
Hawk's Practical Physiological Biochemistry (1937, 1947, 1954, 1965)
Intravascular Phenomena, NIH (1959)
New and Nonofficial Remedies (1957, 1965)
Pharmacological Principles of Medical Practice (1954, 1958, 1961, 1965)
Sahyun's Outline of Amino Acids and Proteins (1944, 1948)
Standard Values in Blood, Division of Biology, Nat. Res. Council (1952, 1961)
Tice's Practice of Medicine (1946, 1961)

HONORS AND AWARDS

1930 Intern Prize for work on parathyroidism, *Philadelphia General Hospital*
1941 Annual Beaumont Lecture, *Wayne County Medical Society*, Detroit
1944 Gold Medal Award of the *American Medical Association* for exhibit on: The Determination of Prothrombin

1946 Lewis Linn McArthur Lecture, *Institute of Medicine*, Chicago

1950 Named one of ten "greats" in hematology, 1900–1950, by Dr. Wm. Dameshek, *Blood*, 6, 388, April.

1950 Council Award of the *State Medical Society of Wisconsin* for meritorious achievement in the field of medicine.

1951 Guest Lecturer (26 lectures) at universities in Chile, Argentina, Uruguay and Brazil and to medical and scientific societies. (See: Honorary Memberships)

1954 *Modern Medicine Award* for distinguished achievement in recognition of the unveiling of the complex physiology of blood coagulation and its clinical implications.

1954 Conference on Hemorrhagic Diseases planned for the informal and intimate discussion of fundamental problems of blood coagulation in recognition of twenty years of intensive and productive research in that field presented upon the occasion of the dedication of the Eben J. and Helene Carey Memorial Library, *Marquette University*

1958 Special University Lecture in Pathology at *University of London*, London, England

1961 John Phillips Memorial Award presented by the *American College of Physicians* for distinguished achievement in the field of internal medicine. (Miami)

1962 Scientific Writers Award, first place in the First Annual Writing Award Contest of *Southwestern Medicine* for article on the "Mechanism of Blood Coagulation"

1962–

1963 Honorary Chairman of the *International Committee for the Nomenclature of Blood Clotting Factors*

1963 *Alpha Kappa Kappa* Outstanding Alumni Award

1963 *Milwaukee Section Award of the American Chemical Society* given for outstanding service to industry, chemistry and the Section. (also 40-year membership pin and certificate)

1964 *Pere Marquette Faculty Award* in recognition of demonstrated ability to inspire students to seek the ideals of the University and to cause them to grow in knowledge and scholarship for the glory of God and the good of their fellowmen. (May 5)

1964 Award from the *freshman class of 1964* for: whose endeavors have enriched both students and University.

1964 Distinguished Service Award for Research in Medical Science. Armand J. Quick, M.D., Ph.D., is honored by this award of the *State Medical Society of Wisconsin* for his outstanding contributions to the science and art of medicine, through his thirty years of teaching at Marquette University School of Medicine and for his distinguished work in unveiling the complex physiology of blood coagulation and revealing its clinical application through the familiarly known "Quick test". (May 12)

1964 Honored by the Research Committee of the *American Heart Association* for his many outstanding contributions to our knowledge of cardiovascular diseases and particularly for the development of the famous Quick test which is used all over the world in the diagnosis and treatment of thrombotic diseases. (Nov. 10)

1964 Award of Merit of the *Medical Society of Milwaukee County:* For his contributions to the health of mankind through his vigorous and courageous research; For his singular contributions in the field of hemorrhagic diseases, blood coagulation and liver function disorders; For his leadership and outstanding achievements in science, chemistry and medicine; and For his twenty-nine years of teaching excellence as a member of the faculty of Marquette University School of Medicine. (Dec. 10)

1964 *Midwest Chapter of the National Hemophilia Foundation* presented a scroll in gratitude and appreciation for his years of service as Chairman of the Medical Advisory Council. (Dec.)

1965 The *Central Surgical Association* certificate to recognize the many contributions of Dr. Armand J. Quick, Emeritus Professor of Biochemistry, Marquette University School of Medicine, to the practice of surgery by his exceptional and stimulating studies on abdominal clotting mechanisms occurring in many surgical patients. (Mar. 4)

1965 An Honors Achievement Award for distinguished accomplishments in research in angiology presented by *The Angiology Research Foundation* and The Purdue Frederick Company. (Also given to several other Marquette faculty members.) (Oct. 22)

1966 The *Alumni Association of Cornell University Medical College* takes pride in presenting the 1966 Award of Distinction to Armand J. Quick, M.D., Class of 1928, in recognition of his notable achievements in research and the teaching of hematology. His life and work have brought honor and acclaim to his Medical College. New York, N. Y. (April 16)

1966 *Rotary Club of Milwaukee* takes great pleasure in awarding a citation to Dr. Armand J. Quick in recognition of his outstanding contribution to his profession or vocation. (June 21)

1967 *1967 International Award for Heart and Vascular Research* of the James F. Mitchell Foundation for Medical Education and Research to Dr. Paul A. Owren of Oslo, Norway, and to Dr. Armand J. Quick in recognition of their early and independent discovery of factor V, a hitherto unknown factor necessary for normal blood coagulation. Washington, D. C. (May 5)

WPS
HEALTH INSURANCE

REPORT OF MEDICARE-PART B AND WISCONSIN HEALTH ASSISTANCE MEETINGS JUNE 1967

Supplement to WISCONSIN MEDICAL JOURNAL
August, 1967

This supplement reviews the highlights of a WPS-sponsored series of meetings with Medical Assistants to provide information about the administrative procedures of Medicare Part B (Title XVIII) and the Wisconsin Medical Assistance Program (Title XIX). Provider Guides on Title XVIII and Title XIX have also been distributed throughout Wisconsin. Additional Provider Guides or copies of this report are available upon request.

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PART I—MEDICARE PART B (Title XVIII)

MEDICAL ASSISTANTS MEETINGS JUNE, 1967

The Federal Medicare Part B Program was effective July 1, 1966. The first claim was received by WPS on July 28, 1966 and the first payments were made in August, 1966. By December 31, 1966, WPS was receiving about 10,000 claims per week. Paid claims approached one million dollars in volume.

Claims receipts have leveled off at approximately 55,000 claims per month, or about 13,000 claims weekly.

A claim that reaches WPS and is payable without further correspondence is handled in less than 20 days. When there are problems processing is delayed.

CLAIM NUMBERS

It is important to use the correct, complete health insurance claim number. To be complete, it must include the letter suffix which is a part of all health insurance numbers. It must be the individual's *own* number. Any claim that is referred to Baltimore for verification of coverage will result in a blank should the number be incorrect. The Health Insurance Record Center for the entire program is operated by the Social Security Administration in Baltimore.

Some claims are apparently complete so far as the number is concerned, but two or more digits are transposed. This results in WPS being unable to get clarification or authorization to pay the claim. In most instances, the health insurance number is on the patient's Health Insurance Card. In the few instances where you cannot get a number from the patient, call the closest Social Security Office and they will provide the correct number. To obtain a number from the local Social Security Office, you must have the following information: (1) patient's correct and complete name; (2) correct address; and (3) birth date. This information helps the Social Security Office to identify the patient. It is important to make every effort to get the number from the patient or his family.

NAMES

Incorrect names cause problems in the handling of a claim and getting it processed for payment. The spelling of the last name should always be correct. Use the given name whenever possible. For the ladies, don't say, "Mrs. John Jones," say "Mrs. Mary Jones." If, for your own records, you require the husband's name because you have a family-type charge record, put his name in parenthesis; but always use the lady's given name.

DIAGNOSES

Diagnosis is another important part of the report. Be sure that the diagnosis given is meaningful. Some very peculiar diagnoses come from patients who submit their own claims. Most of the time they are not very revealing and sometimes misleading. In an instance where the diagnosis is such that you do not wish it to be revealed to the patient, use a code. Any standard code may be used as long as you indicate what code you are using. If you do not use codes and find it necessary to submit a claim with this type of diagnosis and the patient is going to see it, you may submit one without the diagnosis. However, be prepared to expect a telephone call from WPS for the diagnosis. WPS will check other claims, hospitals bills,

etc., first to see whether the diagnosis is on file from some other source for the same period of care. Normally, however, WPS would probably have to call you if it does not appear on the form.

ITEMIZED CHARGES

The heart of any claim is the services performed and the charges for those services. Charges must be itemized in sufficient detail to provide information necessary to make a judgment as to the usual, customary and reasonable level of charges. When you have an unusual case, which results in a charge by the physician that is higher than his usual charge, sufficient description of that service should be on the original report; or, if you are providing a receipted bill, there should be sufficient information on that bill to establish justification for the higher charge.

DATES

Correct dates of service are very important. Some offices use posting dates instead of actual dates of services. In most instances, this will not affect payment of a claim; however, if you have a patient who is under your doctor's care for the last week in May, and on May 31 this patient dies, his coverage terminated as of the month of May. Any claim which involves services that show a date in June is going to be rejected by the computer. The claim will be rejected by the computer on the basis of that date of death.

If you have a claim involving a deceased individual, which was rejected by Medicare Part B, review it to make sure that this might not be the cause.

PATIENTS' SIGNATURES

If you have difficulty in getting the signatures of patients, there are other methods to get the claim handled. Be sure to obtain the signature from the patient at the first opportunity—if the patient is able to provide it. A second possibility is to have a member of the family sign, if there is a member of the family available. In any case where anyone else other than the patient signs, there should be a brief indication of why. An example might be that the patient is unconscious when he is brought in by another member of the family. Ask that person to sign for the patient and indicate on the claim form "patient unconscious." If the patient is blind, the same thing may be done. The explanation should be as short and brief as possible.

AUTHORIZATION TO SIGN

Some medical assistants are authorized to sign for their doctors; there may be others who would like to be authorized to sign for the doctors in their office. To obtain authorization, use the doctor's letterhead and indicate that the following doctor—or doctors—(signatures shown) authorizes your signature to be accepted by Medicare Part B. Your signature, or the signature of each person in your office authorized to sign, should also appear on the letter. As soon as this authorization is on file at WPS, you can begin signing claims for your doctor.

1490 SUBSTITUTES

Some medical assistants prefer, rather than completing the official claim form (SSA-1490), to attach an itemized bill to the 1490, or a photocopy of the ledger entries for the patient. These substitutes are acceptable, but the same itemization of charges and services is needed if WPS is to process a claim from the bill or from the ledger copy. When you use this

type of substitute for the 1490, be sure: (1) that the copy you use is completely legible; and (2) that it is firmly attached to the 1490 when mailed. The 1490 must accompany the claim and the patient's portion must be completed before payment can be made—whether or not the doctor is accepting the assignment. If the doctor is accepting the assignment, he (or his authorized personnel) must sign the claim form as well as indicating that he accepts assignment. If he is not accepting the assignment but is providing an itemized, receipted bill, he does not need to sign the claim form.

If the doctor is not accepting assignments, you can still be a great help to the patient if you assist the patient to complete his claim form. WPS provides an instruction brochure (Med. 23–6612), which is designed to help patients send in their claims. You may order a supply for your reception area.

SPLIT PAYMENTS

When a claim covers services in both 1966 and 1967, the Law requires WPS to treat it as two claims—one claim for the services in 1966 and one for the services in 1967. This results in split payments. WPS usually can approve both parts at the same time, but sometimes the claims become separated and are paid on different days. Or one may result in a notice and one in a payment. If you get what appears to be a payment of part of a claim or a notice concerning part of a claim, please wait for a few days because you probably will soon receive the clarification of the remainder of that claim.

$50 DEDUCTIBLE

The patient must pay a $50 deductible each calendar year. The year ends on December 31 and on January 1 the patient is again subject to the $50 deductible.

There is a carry-over provision where any charge incurred during the last three months of a calendar year, which is applicable to the $50 deductible for that calendar year, will also be credited to the next calendar year's deductible. Deductibles incurred in July, August and September of one year do not carry over to the next year. Charges that are incurred and applied to the deductible in October, November and December do carry over. If the patient had only one claim—$50 in August—that $50 will be applied to that year's deductible. Whenever he has a claim in the next year, he will have to meet his $50 deductible again. However, if the claim was in October instead of August, it would be applied to that year's deductible and it would also meet his deductible for the next year.

MULTIPLE CLAIMS

When you have problems with patients who are unable to understand their deductible as it is applied on various claims, refer questions to WPS to check the individual case. There may be a deductible incurred in other states from other carriers, and the only way such information could be verified is from records in Baltimore. It is not possible for you to try to determine the deductible when there are multiple claims involved.

Your office may have the policy of collecting the $50 deductible plus 20% of the remainder of the bills at the time services are rendered or at the time services are completed. However, it is extremely difficult for you to know, or the patient to be able to tell you whether he has had a previous claim. In many instances (especially those where the patients have been hospitalized) there can be other claims. Hospital-based physicians' charges may be involved, and they may have already been credited to the deductible. This means you may collect more from the patient than his actual

liability. In this instance, when WPS receives information from Baltimore that instead of the $50 deductible the patient has only $20 to meet, WPS must pay part of the benefit back to the patient to cover the amount of overpayment. However, you will receive the Explanation of Benefits for the complete amount and your check will not agree with the amount that is indicated at the bottom of the Explanation of Benefits form. If you get that type of an explanation you will find that the amount of your check is the amount that your 1490 indicated was the balance due on this claim to the doctor. Please check your records before returning it. In most cases, you will find that the payment is the amount your report indicated was due to the doctor. If you check and find that WPS has made an error in splitting these payments, then send them back for correction, but please be sure to check your own records first.

WPS cannot pay any provider more than the balance due on his bill. If the patient has paid a portion of the bill, the patient is entitled to reimbursement for any amount he has overpaid his liability.

DUPLICATE CLAIMS

Sometimes you may complete a claim in the doctor's office and the patient also completes one. Sometimes these are sent in without a receipted bill and the one the patient sends in may cause a problem. Follow-up claims submitted without a specific indication that they are duplicates are another problem source. If you send a follow-up claim, please be sure to note *on the claim form itself* that it is a duplicate of a claim sent earlier.

When you have a chronic patient who comes in regularly sometimes the claim will be submitted for three or four months at a time since the bills are not extremely large. Please be sure that the third or fourth month is not included again on the next three or four-month report.

When telephoning or sending copies of Explanation of Benefits forms or copies of checks, be sure to indicate why they are being sent. When these are sent in without comment, they are forwarded to the Medicare-PLUS $15,000 claims unit. If they do not find any coverage for the patient, there is a delay in determining your intention.

MEDICARE-PLUS $15,000

WPS has a Medicare supplemental policy for people over age 65 called Medicare-PLUS $15,000. This is a regular WPS insurance policy, and WPS cannot use the Medicare 1490 claim form to process these claims. No private insurance payment can be processed from the Federal Medicare claim.

How do you submit a Medicare-PLUS $15,000 claim?

The best way to submit a WPS claim is to send a copy of the voucher (called Explanation of Benefits) after you have received payment from Federal Medicare. Write the diagnosis on this form, and direct it to Medicare-PLUS $15,000. Another way is to send a regular PSR (Physician's Service Report). Provide the diagnosis and indicate what Medicare paid. If the Physician's Service Report is received without an indication of what Medicare paid, WPS must assume that the doctor is not accepting assignment and the patient is unable to pay the bill. To speed payment on this claim, WPS will pay according to the policy. However, payment in this case may not correlate with Medicare payments.

PART II—WISCONSIN MEDICAL ASSISTANCE PROGRAM (Title 19)

From the beginning of this program in July, 1966 through December, 1966, WPS processed 171,000 claims and paid $3,019,000.

From August, 1966 through April, 1967, WPS processed 478,320 claims and paid a total of $6,205,000. In the recent three months, WPS received 196,809 claims and processed 237,226. Of the 70,000 claims received in April, 1967, 33,000 were from physicians' offices.

The Wisconsin Medical Assistance Program is operated by the State Welfare Department and WPS is the contractor for processing and handling claims in the area outside Milwaukee County. Eligibility is determined by the local county welfare department and can be determined by a card issued to the patient. The yellow card is Group I, which is the greater level of benefits; the green card is Group II and is the lesser level of benefits. Check these cards carefully because the level of benefits can change or eligibility can expire.

To assure payment as quickly as possible, complete the claim form accurately. Record the certification number in the appropriate space on the claim form. Your provider number is a 5-digit number which has been assigned to your doctor and the computer uses this number to write a check to your office. If you transpose the number, the computer will write the check to another doctor. It is important that this number be correct.

CLAIM FORM CARBONS

WPS receives two copies of the Title 19 claim form and records the amount to be paid on the top copy, which goes into files in the Claim Department. The second copy goes to the keypunch section to write the check. If the carbon was missing it is possible that a claim could be processed with nothing on the code sheet to indicate payment. When you remit Title 19 claims, please remove only your office copy and one carbon.

UNDER AGE 65 AND MEDICAL ASSISTANCE BILLING

The Medical Assistance Program (Title XIX) pays benefits after all other sources of payment have been exhausted. If there is private insurance involved, you should collect from the private insurance organization before a Medical Assistance claim is filed for any balance that remains.

When a person over age 65 is eligible for Title XIX and for Medicare, WPS can only pay the $50 deductible and 20% co-insurance during a calendar year. That is the maximum, even though the patient might not have benefits under Federal Medicare.

When Title XVIII and Title XIX are paying on the same bill, there is a possibility of overpayment. If there is an overpayment when dual entitlement is involved, refund to the Medical Assistance Program. If you receive payment for many patients in one check, cash the check and only refund the overpayment. Be sure that you identify the patient and give WPS his Medical Assistance number.

The best way to file a claim for a patient with dual entitlement is to use the Medicare 1490 form only. Complete the form—original and carbon—put Medicare and Title XIX numbers on each of the forms and staple them together.

BILLING

The Medical Assistance Program indicates that contractors are to pay monthly, so you may wish to bill monthly between the first and tenth of the month. When Title XVIII and XIX are both involved, WPS suggests that you remit claims monthly, although WPS has often paid benefits two or

three times a month in an effort to get payment to you as quickly as possible.

Please wait at least two months following the billing date before you inquire. In some instances, certification must be established from the county welfare departments, and this may require extra processing time.

PART III—QUESTIONS AND ANSWERS

Q. How do we know when a patient has met his deductible?

A. You can seldom be certain of this because there may have been credits from visits to other doctors, from services of hospital-based physicians, or from outpatient hospital services.

Q. How do we know how much to bill the patient when we are accepting assignments?

A. You may bill 20%, indicating to the patient that you may have to bill again for any part of the $50 deductible still to be met. You may also bill for $50 plus 20% with the possibility of having to make a refund. The preferred method is to wait for Medicare payment and then bill as necessary.

Q. When a patient is covered by Medicare Part B and Medical Assistance, where is the claim sent?

A. Medicare will pay first. The Medical Assistance claim will be paid last since it can be paid only after all other sources of payment have been exhausted. If there were different carriers for Medicare and Medical Assistance, it would be advisable to hold the Medical Assistance claim until payment by Medicare was received. This delay is unnecessary when the two programs are handled by the same carrier. The best method for submitting a claim with eligibility under both programs is to complete the 1490 *in duplicate,* with the Medical Assistance number placed immediately below the Health Insurance Claim Number. *Staple the two copies together* and send them to WPS. Another good method is to submit Medicare alone and await payment. When payment is received, send the Medical Assistance claim form to WPS with a copy of the Explanation of Benefits form attached.

Q. What if we wish to follow up a claim?

A. Please write to WPS, listing patient's name and Health Insurance number. Never send a duplicate claim without writing "Duplicate" prominently on the claim form.

Q. What are major reasons for delay in processing claims?

A. Most common reasons are incorrect names, numbers, or an inadequate description of services rendered. The latter must be in sufficient detail to allow judgment as to the usual, customary and reasonable level of charges allowable.

Q. What are the most common errors on claims?

A. (1) Patient's name disagrees with signature or is not legible.
(2) Claim number does not include suffix or is spouse's number instead of patient's number.
(3) Items 2, 3 and 4 are not answered.
(4) No signature of patient or authorized substitute.
(5) Inadequate description of services or itemization of charges.
(6) Amount paid—must usually be paid in full if doctor does not accept assignment.
(7) Shows neither full payment nor acceptance of assignment.

Facts about

WISCONSIN PHYSICIANS SERVICE

the Blue Shield Plan of the State Medical Society

Established as a Blue Shield Plan in 1946, **WPS** is known as "The Doctors' Plan" . . . the non-profit Health Care Program specifically designed for the people of Wisconsin by physician-members of The State Medical Society of Wisconsin.

WPS also is a Contractor for the Administration of the Wisconsin Medical Assistance Program (Title XIX), and is the Carrier for the Part B (surgical–medical) portion of the Federal Medicare Program throughout Wisconsin, except Milwaukee County.

As of January 1, 1967, the total number of persons (including all family members) covered by **WPS** and those eligible for State and Federal Programs serviced by **WPS** were as follows:

WPS Participants	415,118
Medicare Part B	315,000
Wisconsin Medical Assistance Program	125,000

We welcome questions you may have concerning the services and functions of The State Medical Society of Wisconsin. Please visit or telephone whenever we can be of service. The telephone number of Medicare Part B is 257–0761. The telephone number of the Wisconsin Medical Assistance Program is 257–0262.

WPS

HEALTH INSURANCE

WISCONSIN PHYSICIANS SERVICE

THE DOCTORS' PLAN OF THE STATE MEDICAL SOCIETY

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the wisconsin medical journal

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Anterior Cervical Fusion for Cervical Disc Disease

By GLENN A. MEYER, M.D., and MORRIS B. GLOVER, M.D.
Madison, Wisconsin

■ WE ARE REPORTING the results of the first 21 cases of degenerative cervical disc disease treated by anterior cervical fusion (Cloward method) at the University of Wisconsin Hospitals. We include a description of diagnostic and therapeutic approaches found to be useful and a brief review of some pertinent anatomical facts gathered from the literature.

Patients with pain in the neck and its environs have come under the diagnostic scrutiny and treatment of various medical specialists as well as family physicians. Neurosurgeons, orthopedists, radiologists, neurologists, and psychosomaticists have all concerned themselves with such patients. Some of the reports in the medical literature manifest a striking over-simplification of a clinical problem which is frequently complex.

In many medical centers the diagnosis and treatment of cervical disc disease is still rapidly evolving despite the fact that cervical disc disease has been surgically treated for several decades. Mixter in 1935 reported that 7 of his first 33 cases of surgically treated disc disease were of the cervical area.[1] It was soon recognized that great differences existed in clinical characteristics and response to surgical therapy of degenerated discs in different areas of the spine. The gratifying results obtained by removing the herniated lumbar disc of a patient suffering from severe sciatica could not be duplicated consistently in the cervical area. In contrast, many of the degenerated cervical discs either contained or were surrounded by hard calcific material and attempts at removal not only failed to consistently relieve symptoms, but occasionally caused a marked increase in neurological symptomatology. A new and alternative approach to the degenerating cervical disc was needed. Dereymaeker in Belgium and Smith, Robinson, and Cloward in the United States made important contributions in the development of the anterior approach to cervical disc problems.[2,3,4]

Between the two milestones already mentioned, brief flurries of enthusiasm occurred over two lesser contributions in the management of cervical and upper extremity pain problems. In the late 1930s the injection of "trigger points" in the paravertebral and shoulder musculofascial structures was popularized.[5] In the 1940s the "anterior scalene syndrome" came into vogue with surgical section of the anterior scalene muscle and/or adjacent bony structures.[6] The goal of such efforts was to relieve neurovascular compression in the "thoracic outlet." Both of these concepts contributed to the understanding and treatment of cervical and upper extremity pain problems, particularly after recovery from an initial overenthusiasm for the procedures.

Doctor Meyer's current address is: Division of Neuropsychiatry, Walter Reed Army Institute of Research, WRAMC, Washington, D.C. 20012.
Reprint requests to Morris B. Glover, M.D., Division of Neurological Surgery, University of Wisconsin Medical School, Madison, Wis. 53706.

Basic Anatomical Concepts

Some of the concepts which we have found to be clinically helpful are:

(1) The intervertebral disc, despite its lack of direct vascular supply, is a dynamic structure and reaches its mature state about the end of the second decade of life. Injury to the disc or adjacent vertebral body initiates reparative processes with a proliferation of fibro-cartilaginous tissue and/or granulation tissue. Most of the bony or "osteophytic" material at a degenerated vertebral interspace is an outgrowth of the bony margins of the vertebral body, particularly from the area of the uncovertebral or Luschka's joint. An aging process routinely occurs with lowering of the water content of the nucleus pulposus, loss of elasticity, and finally, replacement of part or all of the nucleus pulposus with fibro-cartilage.[7,8]

(2) The presence of a major spinal structural abnormality such as a congenital or acquired fusion gives the patient a marked predisposition to develop symptomatic disc disease.[9]

(3) A narrow diameter of the cervical spinal canal in the A–P dimension is a definite predisposing factor to neural compression. In all reported series there is a definite correlation with the degree of neurological impairment.[10]

(4) The radicular arterial supply to the cervical spinal cord is so variable that crucial radicals cannot be predicted. However, about 10% of the population has no significant arterial radicals at the three nerve root levels C7 through T1 and therefore such individuals are markedly dependent on the anterior spinal artery in this area.[11]

(5) The ligamentum flavum loses its elasticity with age. The ligament may fold inward, particularly with disc collapse at the same interspace, and encroach upon the spinal canal.[10]

(6) Nerve roots are susceptible to both external compression by osteophytic spurs and less commonly to fibrosis and angulation within the dural sac. A corollary to this is that the ventral roots may be severely compressed with complete sparing of the dorsal roots. One reason for this is that the ventral roots are closer to the uncovertebral or Luschka's joint area.[12,13]

(7) Certain individuals have a congenital or metabolic predisposition to disease of multiple discs. With x-ray and clinical evidence of generalized disc disease, disc surgery has significantly less chance of success and may be contraindicated.[14]

(8) The exact role of trauma as an etiologic agent in cervical disc disease is extremely difficult to assess in any retrospective study. Unequivocally, trauma may be the major etiologic factor in an individual case. However, almost all series of cervical disc problems report a large percentage of patients who are completely unaware of any significant trauma to their vertebral column.

Diagnostic Approach

The initial evaluation of a patient includes careful neurological history and physical examination. The degree of movement of the cervical spine is noted as well as signs of nerve root irritation or vertebrobasilar insufficiency caused by extremes of motion. An examination of motor power at all joints of the upper extremity is carried out with emphasis on the intrinsic hand musculature. Search is made for atrophic or fasciculating muscles in the entire arm and shoulder girdle. In most cases detailed charting of individual muscle strength by the physical therapist is also done. Complete spine x-ray studies are obtained including both oblique and flexion-extension views. Particular note is made of subluxations, size and location of osteophytes, and the antero-posterior diameter of the spinal canal.

In some cases electromyography may be of great help to determine which ventral roots are implicated on the basis of denervation potentials in specific muscles. The cystometrogram as an evaluation of bladder function is less helpful than in cases of cauda equina compression; but, occasionally may be useful.

A complete myelogram is carried out on all patients prior to surgery. The myelogram is of great value in certain cases to rule out a spinal cord tumor and to plan the surgical approach most appropriate. In the course of mylegraphy emphasis is placed on the cross table lateral view with the patient in the ventral decubitus position to determine the degree of anterior encroachment upon the spinal canal. On the same view frequently marked infolding of the ligamentum flavum with posterior encroachment on the spinal canal can be seen, particularly with the neck hyperextended. Detailed spinal manometrics

prior to myelography are frequently done and occasionally abnormal findings are obtained; however, the results are rarely of great clinical value. In certain cases of cervical disc disease the manometric examination will indicate a block only with the neck hyperextended.[15]

A series of six cervical discograms was done. The films were of diagnostic value in only one case. Routine use, considering the morbidity of the procedure, is probably not justified.[16]

Psychosomatic and occasionally psychiatric consultation is obtained freely where significant psychogenic overlay is felt to be present.

Operative Cases

This is a study of 21 consecutive patients subjected to 24 operative procedures for the fusion of 37 cervical interspaces from Nov. 23, 1962 to May 31, 1966. All of the cases were operated on for degenerative cervical disc disease. Seven patients operated for stabilization of cervical fracture dislocations have been eliminated from the study. Seventeen of the cases were operated by the authors. Excellent follow-up was obtained on 20 of the 21 cases with serial neurological examinations. Follow-up cervical spine x-ray films were obtained in all but one case. One patient was followed by telephone calls both to the patient and to her personal physician. The minimum period following surgery is 6 months, the median follow-up period is 18 months and the average 21 months. The series consists of 15 males and 6 females of the age range 43 through 71. Five of the patients were in the fifth decade of life, 12 were in the sixth decade and 4 were age 60 or older.

Four of the patients gave a history of recent (less than 6 months) trauma, 9 gave a history of old trauma, and 8 were aware of no neck injuries. Only one of the patients showed signs or symptoms of major sphincter disturbances and 2 others complained of minor disturbances in the form of chronic constipation. Three patients manifested signs and symptoms of a major gait disturbance, 5 had minor difficulties.

Table 1 lists the first symptom and the chief complaint of this series of patients in tabular form. It should be noted that several patients had more than one chief complaint and 2 patients had the simultaneous onset

TABLE 1—*An Analysis of Symptoms in 21 Patients Subjected to Anterior Cervical Fusion*

	First Symptom	Chief Complaint
Mid-line or Spine Pain	6	3
Shoulder Pain	0	2
Arm and Hand Pain	6	10
Leg Pain	1	2
Sensory Loss	2	5
Weakness	4	3
Gait Disturbance	3	5
Headache	1	1
Dizziness	0	1

of two symptoms. A striking feature is that only 3 patients gave weakness as their chief complaint even though 14 of the 21 patients had definite objective weakness when examined. As in other series pain is a prominent feature of most cases. Sphincter disturbance is seen either not at all or very late in the course of the disease. There was a focal decrease in one of the deep tendon reflexes of an upper extremity in 7 cases. This carried a poor correlation with the standard myotome charts and was not of great use in determining the level of the offending disc. Eight of the cases had a focal radicular type sensory loss often only to pin prick. This carried a fair correlation with the level of involvement and the examiner could predict the level of the offending disc within one interspace.

Seventeen of 21 cases manifested at least one narrowed interspace at a symptomatic level usually associated with some degree of osteophytic spurring. Three of 21 patients manifested only minor changes and one set of roentgenograms was felt to be entirely normal. At myelography all 21 patients manifested some degree of anterior defect as seen in the cross table lateral view. Three demonstrated a partial block to the flow of the contrast material and 9 manifested a lateral defect in the column of contrast. Spinal fluid protein levels were reported in 20 cases and were of the range 24 to 96 mg per cent. Eight were less than 40, seven were 40 to 60 and five were in the range of 60 to 96.

All operations were carried out under general endotracheal anesthesia utilizing the standard Cloward technique (Fig 1). In 17 instances the 5–6 disc space was fused, in 15 the 6–7 interspace, in 4 the 4–5 interspace and in one case the 3–4 interspace. This is in agreement with other series except that our incidence of involvement of the 4, 5 disc was less than most. In 12 instances one interspace was fused, in 11 instances two in-

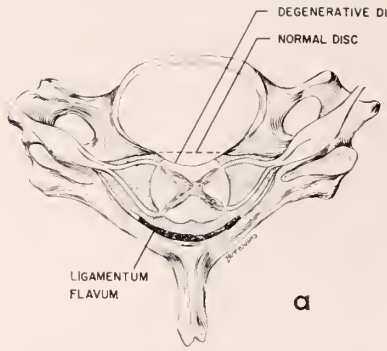

Fig. 1—(a) Cross section of cervical vertebra and cord showing degenerated disc indenting dura and cord.

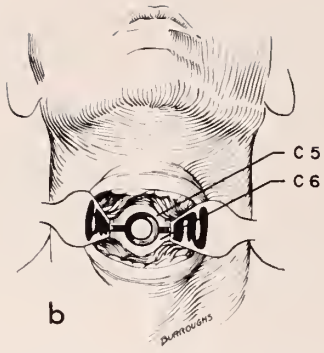

Fig. 1—(b) Operation. A hole is drilled between the C5–6 bodies down to the anterior spinal ligament thus removing the hard degenerative disc.

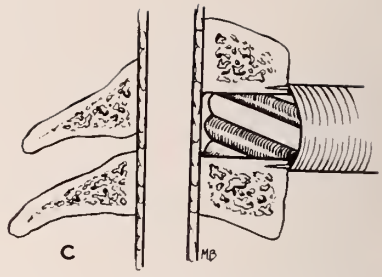

Fig. 1—(c) Sagittal view showing drill in place between C5–6.

terspaces, and in one instance three interspaces. Graft material utilized was autogenous ilium in 28 interspaces and in the nine remaining interspaces prepared heterogenous bone (Squibb). It was found that the prepared bovine graft material was somewhat softer than autogenous bone; but, in all cases where radiologic follow-up was obtained fusion occurred. Only one complication was encountered possibly because of utilization of a bovine implant. In this instance the patient awakened from the anesthetic prematurely. He arose from the operating table and gave a rather violent cough with forceful flexion of the neck, thus fracturing the Bo-Plant necessitating replacement with autogenous bone at a second procedure. In this patient, therefore, autogenous ilium was utilized at one interspace and bovine implant at another. No difference in fusion characteristics could be determined at detailed radiologic follow-up several months later.

Three of the patients had prior surgical procedures. Two had had cervical laminectomies and one had had an ulnar nerve transplantation.

There were four major complications, prolonging the hospital stay. One of the cases very early in the series had marked neurological deterioration following fusion and required extensive rehabilitation. There were two cases of infection of the graft donor site at the ilium. One of these progressed to osteomyelitis and required a marsupializing procedure. The other major complication is mentioned above in our description of graft material. There were six minor complications of transient nature not significantly lengthening the hospital stay. There were five cases of dysphagia and one of dysphonia. There was no incidence of recurrent nerve paralysis and no late gibbus formation at the fusion level in these patients. Graft instability with pseudoarthrosis formation was not found to be a problem in this series. Nine cases had follow-up flexion-extension views of the cervical spine and in all cases the fusion was felt to be stable.

TABLE 2—*Results at Follow-Up Examination of 21 Patients Subjected to Anterior Cervical Fusion*

	Predominantly Radicular Symptoms	Predominantly Myelopathic Symptoms	Total Cases
Excellent	7	0	7
Good	6	2	8
Satisfactory	1	3	4
Poor	0	2	2
Totals	14	7	21

Table 2 describes our results in the 21 cases. The division into predominantly radicular and myelopathic groups was somewhat difficult because about one-third of the patients had combinations of signs and symptoms. However, the assignment of patients into the two groups was made prior to evaluation of the results and an objective division was felt to be obtained. An excellent result is defined as one in which the patient has no significant signs and symptoms, is carrying on with all his usual activities, and requires no analgesics. A good result is defined as one in which there is marked remission of signs and symptoms and the patient is able to carry on his usual activities infrequently requiring analgesics for pain relief. A satisfactory result is defined as a minimal to moderate remission in signs and symptoms with some degree of physical

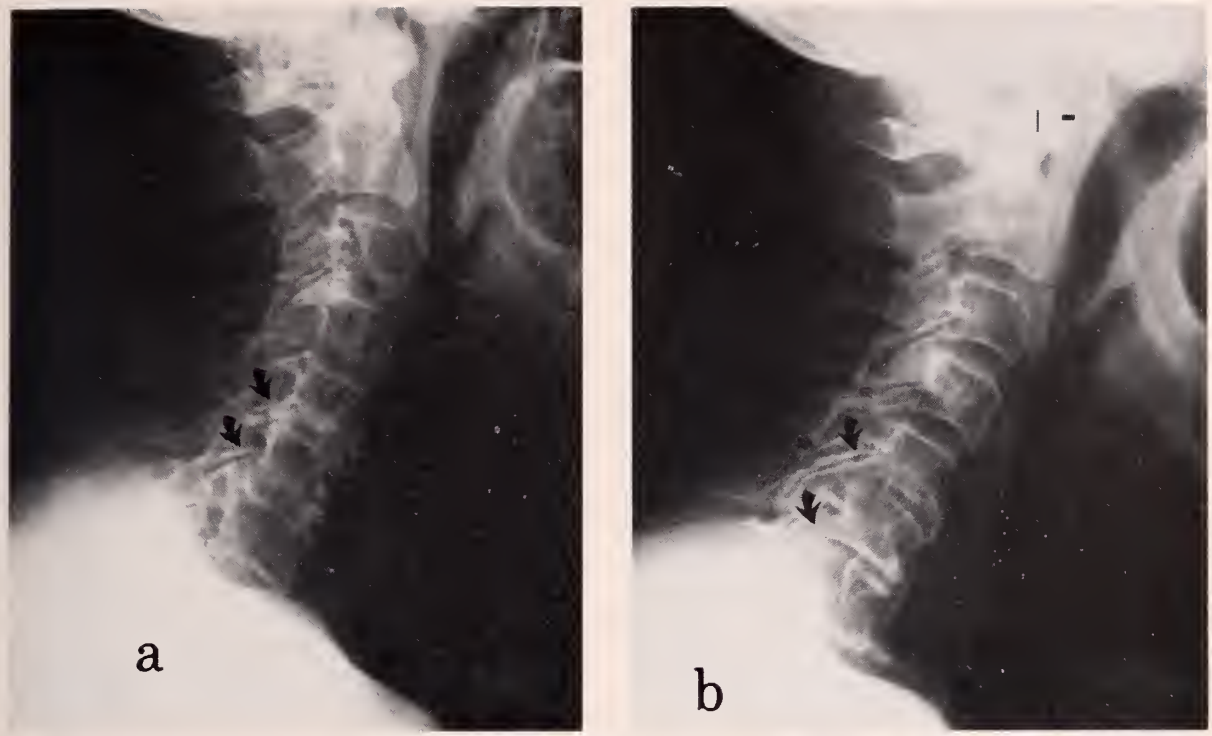

Fig. 2—Pre-fusion (a) and post-fusion (b) lateral x-ray films of the cervical spine to show removal of posterior osteophytes.

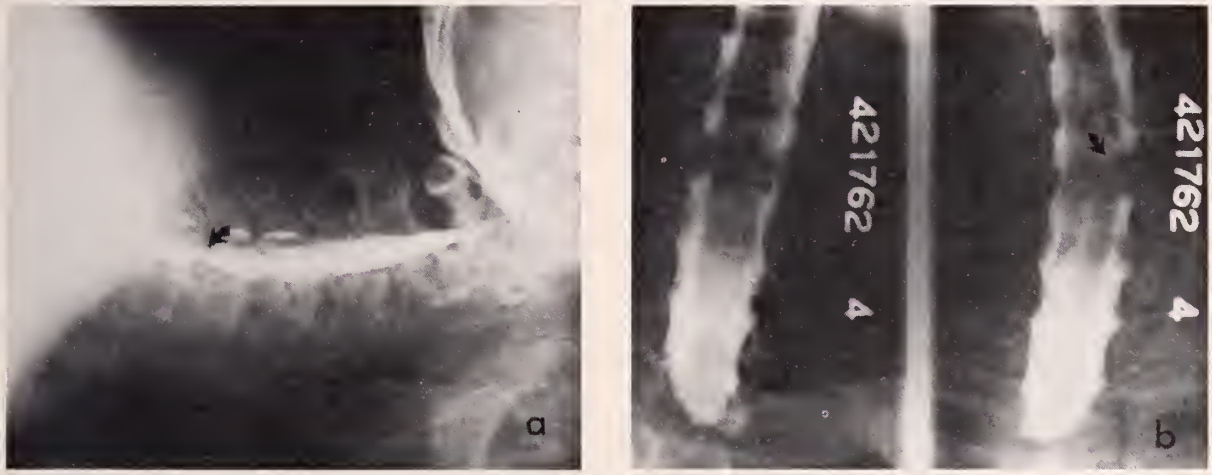

Fig. 3—The cross table lateral view (a) demonstrates the anterior encroachment on the dural sac. The A-P views (b) show the same degenerated disc—C5–6—with the usual lateral myelographic defects. Lesser degrees of degeneration are seen at adjacent levels.

impairment. A poor result is defined as one in which there is either no change or deterioration in the neurological condition.

Comment and Discussion

It is our impression, in agreement with other neurosurgeons, that the results obtained in our first 21 cases of anterior fusion justify enthusiasm for the procedure. As reported in other series the procedure has its greatest usefulness in cases with predominantly radicular symptomatology in one or both upper extremities. As in other series our results with patients having primarily myelopathic symptoms are less favorable. However, the prevention of additional deficit may be all that can be expected in some cases.

In our opinion the Cloward method offers significant advantages over the Smith–Robinson method because the offending osteophytes can more easily be removed (Fig

Fig. 4—An oblique view demonstrates severe posterolateral or foraminal osteophytosis at the C4–5 and C5–6 levels.

2). Often patients exhibit a striking degree of neurological recovery upon awakening from the anesthetic. With the Smith–Robinson procedure the osteophytes will usually resorb with time provided a stable fusion is obtained. However, this process may take weeks or months and if the graft is not completely stable may not occur at all.

Not described in this communication are seven cases in which anterior fusion was employed in the treatment of traumatic fracture–dislocation of the cervical spine. Anterior fusion is of help in certain selected cases; but, in other cases the procedure may be of no help and indeed may have deleterious effects.

Immediate surgery for cervical disc disease is not recommended except in cases with severe neurological dysfunction where it is feared that irreparable neurological damage may result from delaying operation. Conservative therapy with conventional modalities is used in all other cases including heat, massage, cervical traction, immobilization of the neck with a collar, analgesics, and avoidance of potentially traumatic situations. If after several weeks of conservative management the patient fails to improve or if there is objective evidence of neurological deterioration, operation is recommended. Our two commonly used surgical techniques are the anterior discectomy and fusion by the method of Cloward or posterior laminectomy with or without medial facetectomy and unroofing of the nerve root canal with the high speed air drill. Posterior fusions have been carried out only in cases of atlanto-axial instability or dislocation. The operative procedure is carefully individualized depending upon the clinical situation. In several instances a combination of an anterior and posterior approach has been utilized. Relative indications for the use of anterior fusion are as follows: localized disease involving only one or two interspaces, instability of one or more interspaces as evidenced by subluxation on the flexion-extension film, a large anterior filling defect on myelography, and evidence of definite radicular motor or sensory neurological impairment. Relative indications for the posterior or laminectomy approach are as follows: generalized cervical disc disease involving more than two interspaces, marked symptoms of myelopathy with signs of upper motor neuron interruption in the lower extremities, question of spinal cord tumor, evidence of infolding of the ligamentum flavum, and an interspace that is already fused or nearly fused as evidenced by the flexion-extension view.

Great variation exists in the management of cervical disc problems. At one end of the spectrum some surgical enthusiasts propose that persistent pain in the neck is an indication for surgery even if there are minimal or no objective signs on physical examination. Radiological justification for this is sought in the form of abnormal discograms or minor subluxations on flexion-extension or dynamic views of the cervical spine. Pain in the neck and radiologic evidence of some degree of degeneration of the cervical spine are present in such a large proportion of the population, particularly in the older age groups, that surgery is very seldom justified on this basis alone. It is our opinion that persistent pain in the neck may be a manifestation of underlying psychiatric abnormality, particularly as part of a compensation neurosis.

At the other extreme proponents of conservative management regimens, particularly in England, have almost excluded surgery

from the therapeutic armamentarium. A report from one such group precisely documented the downward course of 44 conservatively managed patients over a period of up to 32 years.[18] Two of the group died of causes directly related to their neural dysfunction and several others were invalids. We have attempted to find a rational plan of management between these two extremes.

Summary

Patients with symptomatic cervical disc disease frequently present a complex clinical problem. A thorough study often utilizing special examinations and consulting services is necessary. Patients with severe neurological deficit and those failing to improve with conservative measures are candidates for surgical intervention. In 14 cases with primarily radicular symptomatology anterior cervical dissectomy and fusion by the Cloward method has been found to give more than 90% excellent or good results. In other cases laminectomy alone or in combination with anterior fusion is the procedure of choice.

ACKNOWLEDGMENT: We wish to express our thanks to the E. R. Squibb & Sons Company for supplying the Bo-Plant processed heterogenous bone (prepared bovine bone graft material) used in several of the cases.

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BOOKLET TO STIMULATE TUBERCULOSIS ERADICATION

A new booklet, designed to stimulate active participation in the effort to eradicate tuberculosis, is currently receiving widespread distribution throughout the United States.

Produced by Lederle Laboratories, division of American Cyanamid Company, the 20-page booklet is entitled "A Gift to the Future."

The publication offers "a working plan to help eradicate tuberculosis" and highlights the importance of tuberculin testing of all school children. A special appendix provides information on school tuberculosis testing programs in the 50 states. The booklet also gives background information concerning the disease itself and facts about the overall nationwide program for its eradication.

"A Gift to the Future" is being made available to state health officers, medical societies, members of Congress, the national headquarters of various civic organizations and state and local tuberculosis associations. Additional distribution of the publication will be made available to school administrators and parent-teacher organizations.

The booklet was prepared by the Physicians Community Service at Lederle Laboratories, Pearl River, N. Y. Single copies are available upon request.

NEW TRAINING FILM ON EMERGENCY RESUSCITATION

"Prescription for Life," a new film designed as a basis for training courses in emergency heart–lung resuscitation, is now available on a rental or sale basis from local Heart Associations or the AHA National Office.

The 16mm, 48-minute color film provides detailed anatomic and physiologic experimental and clinical information covering emergency resuscitation, including airway, breathing, circulation and definitive treatment.

Produced by Bandelier Films and co-sponsored by the American Heart Association and its affiliates in Arizona, Michigan and New Mexico, the film is primarily of interest to physicians, medical students, nurses and hospital staff.

Compression Fixation of Bone

By PAUL A. JACOBS, M.D., and GARY N. GUTEN, M.D., Milwaukee, Wisconsin

■ FIXATION OF FRACTURES with internal metallic instruments has been performed in many ways, with many devices, for many years. For example, Lambotte[1] in 1907 used screws, and later, designed metal plates to fix fractures. Konig had recommended internal fixation as early as 1902, but did not publish his technique until 1931.[2] Other investigators here and abroad have described their techniques and instruments for internal fixation.[3–6]

Recently, a new technique of internal fixation has been developed by the Association for Osteosynthesis Institute (AOI), a group of Swiss physicians.[7] The AOI technique provides total, rigid internal fixation through the use of specially designed plates, screws, and other instruments, including an internal compression device which is used only during surgery.

The purpose of this article is to describe the AOI technique and present results and examples of some of our cases using compression plating.

The AOI technique differs from other techniques of internal fixation in two ways:

(1) A compression device is used to close the gap at the fracture line securely and to prevent any movement of bone ends at the fracture line.

(2) A sharp tap is used to pre-thread the fractured bone before the screws are inserted. Pre-threading prevents heat necrosis and thereby enables the specially designed AOI screws to hold securely during the entire healing process.

When the AOI compression technique was used to fix fractures in studies with animals,[8] new bone formed directly in the mesenchymal stroma three weeks after surgery and almost no cartilage formed within the medullary canal. Whereas in fractures treated without compression, cartilage formed within the medullary canal.

Presented as a Scientific Exhibit at the 125th Annual Meeting of the State Medical Society of Wisconsin, La Crosse, May 9–12, 1966; and The American College of Surgeons, San Francisco, Calif., October 1966.

Doctor Jacobs is Clinical Instructor of Orthopaedic Surgery, Marquette University School of Medicine.

Doctor Guten is Orthopaedic Resident, Marquette Affiliated Orthopaedic Residency.

TECHNIQUE

The basic steps in the AOI technique are described briefly in Figures 1 to 5.

After the fracture is reduced, the plate is attached to the first fragment. Each hole is drilled using a guide to insure that the hole is exactly perpendicular to the cortex. Threads are cut in the cortex with a tap, and a bone screw of appropriate length is then inserted into the threaded hole.

In Figure 1a, the compression device is attached to the bone with a bone screw. The hook on the compression device is inserted into a special hole at the end of the compression plate. In Figure 1b, the compression device is tightened with the compression wrench. This pulls the two bone fragments together with great force and efficiency. Note that the fracture gap has

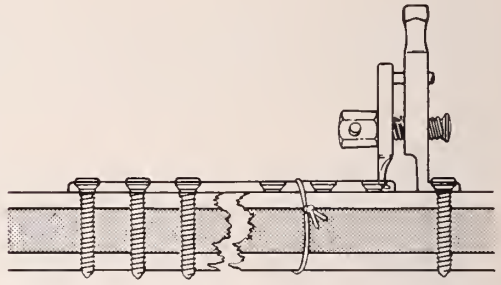

Fig. 1a—To the reduced fracture, the plate is attached to the proximal fragment and the open compression device to the distal fragment. Note the open gap at the fracture site.

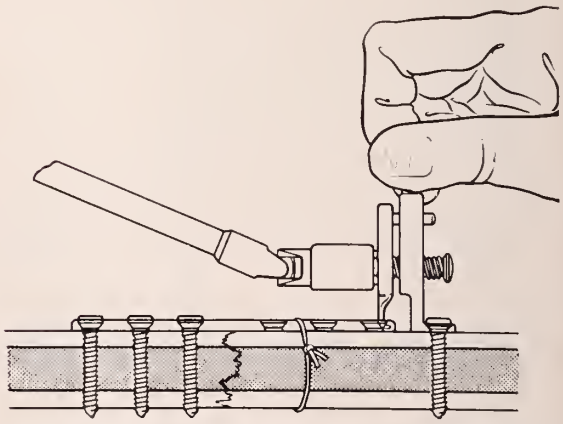

Fig. 1b—The compression wrench closes the compression device. Note the loss of gap at the fracture site.

Fig. 2a—(Case 1) Preoperative x-ray showing hip dysplasia and arthritic changes.

Fig. 2b—Postoperative varus osteotomy using a right angle compression plate.

been obliterated. Since the compression device is attached to the second fragment and the plate is attached at the first fragment, the closing force is possible only at the fracture site. The plate is then attached to the second fragment by drilling, tapping, and inserting the bone screws. The compression device is then removed, and the final screw inserted in the last hole of the plate.

CLINICAL EXPERIENCE

We feel that the indications for compression plating are:

1. Osteotomy
2. Acute fractures
3. Multiple injuries
4. Non-union of fractures

The following cases, which were operated at Mt. Sinai Hospital, Milwaukee, and Milwaukee County General Hospital are typical of those we have treated, illustrate the usefulness of the AOI technique in various types of orthopaedic situations.

Case 1—Osteotomy (Fig 2). A 48-year-old woman developed a secondary osteoarthritis as a result of a congenital dysplasia of the hip. She was first seen in February 1964 and maintained on conservative therapy. Gradually, her pain and disability increased and in January 1965, we performed

Fig. 2c—Six months postoperative varus osteotomy. Union is complete.

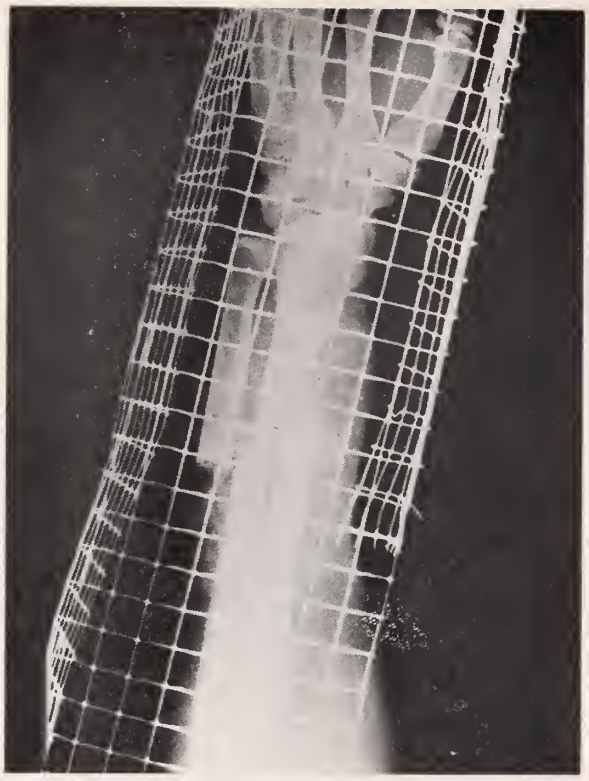

Fig. 3a—(Case 2) Compound fracture of radius and ulna.

Fig. 3b—Postoperative x-ray of compression plating. Note screw holes used for the compression device and absence of a cast.

Fig. 3c—Union is complete and function is excellent five months postoperatively. Note absence of periosteal callus.

a varus osteotomy and soft tissue release using the AOI technique. When she awoke after surgery, she was completely relieved of pain. In three days, she was able to lift her leg and move it without pain. Nine weeks postoperatively, she was allowed partial weight bearing, and three and a half months later, full weight bearing. She has continued to do well, and two years postoperatively, she is free of pain, has full range of motion, and is able to participate in full activity.

This was our first AOI case, and its excellent results encouraged us to use the procedure in other cases.

Case 2—Acute Fracture (Fig 3). A 29-year-old man sustained massive wounds of his forearm with compound fractures of the radius and ulna in September 1965. His wounds were closed and a traction cast applied to attempt to maintain the length of bone. Because of the massive soft tissue damage, open reduction was not performed until three weeks later when his fractured radius and ulna were treated, using compression plating. No bone graft was employed. A bulky dressing but no cast was applied. Two months later he returned to work; his

Fig. 4a—(Case 3) Compound fractures of the leg, ankle, tarsals, and metatarsals.

fractures healed subsequently with excellent results and function.

Case 3—Multiple Injuries (Fig 4). A 26-year-old man was injured in October 1965 when a 2000-pound casting fell on his right lower leg. He had multiple wounds including a compound fracture of the tibia and fibula, fracture dislocation of the ankle with displacement of the medial malleolus, multiple compound fractured metatarsals, and fractures of the calcaneus and talus. Because of his multiple fractures, it was extremely difficult to stabilize the leg and ankle. In spite of the compound wound, we decided to perform reduction and internal fixation.

We applied the compression plate to the tibia fracture and a screw in the medial malleolus to restore the ankle joint. He was placed in a bulky dressing, but not in a cast. Five months postoperatively, he was able to drive his truck and walk with full weight bearing. The tibia and fibula have healed as have the medial malleolus (the screw has been removed) and the remaining bones of his foot.

Case 4—Non-union (Fig 5). A 45-year-old woman sustained a comminuted fracture of the left humerus in November 1964. The fracture was treated with closed reduction. In September 1965, there was non-union of proximal fracture site and we performed open reduction using a compression plate without bone graft. The upper extremity was

Fig. 4b—Postoperative compression plating of tibia and screw fixation of medial malleolus.

Fig. 4c—Six months postoperative with clinical union and excellent function.

Fig. 5a—(Case 4) Comminuted fracture of humerus.

Fig. 5c—Four months postoperative compression plating for nonunion with excellent result. No bone graft or cast used.

Fig. 5b—Ten months post injury-nonunion present at proximal fracture site.

placed in a sling postoperatively, and no plaster immobilization was used. She began to exercise her arm shortly and had excellent function. Early union was seen by December 1965, and the patient was discharged in February 1966, with the fracture solidly united.

DISCUSSION

Compared with other methods of internal fixation, the AOI technique provides the most favorable conditions for bone healing because it completely eliminates motion at the fracture site and maintains the bone ends compressed and in contact with each other. The AOI technique promotes early rehabilitation by permitting early movement of the fractured limb. In certain cases, it may eliminate the use of casts or postpone their application until postoperative motion has been regained. By permitting early movement, the AOI technique reduces muscle atrophy and shortens the period of disability.

The first use of compression plating in the state of Wisconsin was done in January 1965 by the author (P.A.J.). Since then, approximately 70 cases of compression plating have been done by the staff and residents of the Milwaukee Orthopaedic Residency. Our initial results have been extremely gratifying even though long-term evaluation is not possible at this time. However, the efficacy of

the AOI system has been well documented by Müller in Europe after long-term follow-up of 4000 cases.

The AOI technique has some limitations in that it requires a special technique and special instruments. While it may provide better results and better function of the limb, compression plating, per se, does not constitute an indication for open reduction of a fracture.

SUMMARY

Compression osteosynthesis using the AOI (Association for Osteosynthesis) technique provides results that are superior, in many cases, to those obtained with other methods of internal fixation. As can be seen from our cases, the technique is a versatile one that can be used in the treatment of acute fractures, non-union of fractures, multiple fractures, and osteotomies.

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Wichita Hospital to Train New Specialists in Family Medicine

A new type of comprehensive physician is being groomed to take the place of the old-time family "doc," whose methods and philosophies have changed with the continual advancement of medicine and society.

The American Academy of General Practice, who for more than a year has been leading a movement to establish family medicine as the twentieth primary medical specialty, says he will be called the specialist in family medicine. The new specialty is supported by the American Medical Association and was advocated by a report of the AMA's *ad hoc* Committee on Education for Family Practice and the report of the Citizens Commission on Graduate Medical Education, the widely publicized Millis Commission.

The new specialist will be a specialist in breadth rather than in depth (as the other traditional specialties), according to the Academy. He will serve as the primary physician and provide comprehensive, continuous care for all members of the family unit, utilizing an understanding of the behavioral sciences of psychology, sociology, anthropology and economics in addition to the usual clinical disciplines of medicine. He will practice preventive health care much more intensively than any physician now in practice, with the goal of eventually having an occurrence of illness be considered a medical "failure." He will emphasize ambulatory care and efficient utilization of community health services.

This new specialty will require a 3-year graduate program after the M.D., either an internship and 2-year residency or a 3-year residency where internships are not required for licensure. One of the first of these new graduate programs is at Wesley Medical Center, Wichita, Kan. It is structured precisely on the Core Content of Family Medicine, a blueprint for the new specialty. The Core Content, devised by the Committee on Requirements for Certification of the Academy, approaches definition of the new specialty on the basis of its central elements. From the "core" the specialist in family medicine will then conform his practice to the geographical and human requirements of his area.

Dr. G. Gayle Stephens, an Academy member in practice in Wichita, is director of the Wesley program. It is being built upon an existing 2-year general practice residency and the hospital's internship program.

Graduates of the Wesley program, one of the first such in the U. S., will be eligible to take a certifying examination in family practice now being readied for use. The first such examinations in the new specialty are expected to be given in the summer of 1968. Most of these eligible for the initial round of examinations will be doctors who have been engaged in family practice or full-time medical teaching for at least six years and who have completed at least 300 hours of approved postgraduate medical study.

This group, however, will become ineligible after 1975. Then only graduates of approved family practice residencies, such as the Wesley program, will be eligible for examination. All diplomates of the proposed new specialty board will have to be recertified by examination every six years. No other specialty has such a requirement.

According to Doctor Stephens, the new Wesley program will provide a more integrated graduate training period as stressed by the Millis Commission's report published in 1966. The Millis Commission, a citizens group sponsored by the AMA and headed by John S. Millis, Ph.D., president of Western Reserve University, was one of two major outside-of-medicine study groups reporting last year on the organization of medical service in the United States. Both stressed the need for production of many more primary or family-type physicians.

A Clinical Trial of Indomethacin in Rheumatoid Arthritis

By GERSON C. BERNHARD, M.D., Milwaukee, Wisconsin

■ INDOMETHACIN (INDOCIN) a synthetic anti-inflammatory drug has been investigated clinically by several groups during the past few years.[1-9] Initial reports indicated considerable efficacy of Indocin in a variety of rheumatic disorders. Toxic effects, however, were rather frequent when the uncoated tablets were used in relatively high doses.[1-5] Subsequent reports demonstrated a fairly consistent anti-inflammatory response in patients with gout and ankylosing spondylitis when treated with moderate doses of Indocin capsules.[6,7,10,11] The therapeutic response of patients with peripheral rheumatoid arthritis to moderate doses of Indocin capsules has been variable.[10,11] Further clinical evaluation of this drug in patients with peripheral rheumatoid arthritis is the subject of this report.

The naturally fluctuating course of rheumatoid arthritis makes evaluation of therapeutic response difficult. Reproducible objective criteria of improvement have not been standardized. A system which estimates the cardinal features of joint inflammation, the duration of morning stiffness, the presence of night pain and fatigue and analgesic requirement may provide a reasonably accurate estimation of clinical activity.[18] A simple, reproducible and relatively quick estimation of the inflammatory index has been suggested by Smyth.[10,12,13,14,17] This method is most valid when repeatedly applied by the same clinician and permits one to estimate the therapeutic value of a given drug.

MATERIAL AND METHODS

Twenty-six patients were selected from a public clinic and private practice. All patients had peripheral rheumatoid arthritis by American Rheumatism Association[15] criteria.

Doctor Bernhard is Assistant Clinical Professor of Medicine and Acting Chief, Rheumatology Section, Department of Medicine, Marquette University School of Medicine; Chief, Rheumatology Section, Milwaukee County General Hospital.

From the Departments of Medicine, Milwaukee County General Hospital, and Marquette University School of Medicine.

The clinical features of this group are shown in Table 1.

In all instances, the patient had not achieved reasonable control of inflammation while on a regimen of salicylates and physiotherapy. All patients were ambulatory. One patient was receiving gold therapy during the Indocin trial. Other anti-inflammatory agents, such as oxyphenylbutazone (Tandearil), phenylbutazone (Butazolidin), or hydroxychloroquine (Plaquenil) were discontinued when Indocin was started. Patients taking a corticosteroid drug remained on the same dosage while taking Indocin unless clinical improvement permitted reduction of the corticosteroid dose.

TABLE 1—*26 Rheumatoid Patients Treated with Indomethacin*

Sex:		Female 18	Ratio: 2.25:1
		Male 8	
Age:		51.7 yrs. aver. (25–72)	
Duration:		9.7 yrs. aver. (1–29)	
Stage	I– 3	Class 1– 2	
	II–11	2–14	
	III– 6	3– 9	
	IV– 6	4– 1	

Capsules containing 25 mg of indomethacin (Indocin)* were given three times daily with meals. If this was tolerated, the dose was increased to 25 mg four times daily after one to two weeks; then 50 mg three times daily and finally 50 mg four times daily. No patient received more than 200 mg daily. Most of the patients tolerated and were treated with 100 to 150 mg daily.

Laboratory studies included complete blood count, erythrocyte sedimentation rate, urinalysis, oxaloacetic transaminase, alkaline phosphatase, serum bilirubin, cephalin flocculation, thymol turbidity, serum uric acid, blood glucose and serum protein levels. These were done at regular intervals before and during the Indocin trial. Stool

* Supplied by Merck, Sharp & Dohme.

TABLE 2—*Trial of Indomethacin in 26 Patients with Rheumatoid Arthritis**

Excellent	1
Good	5
Fair	3
Poor	14
Inadequate	3
Total	26

*See text for explanation.

guaiac tests were also performed on some patients.

Clinical appraisal of inflammation was derived from a combination of the patient's subjective determination of severity of arthritis, duration of morning stiffness, analgesic requirement other than salicylates and the physician's estimation of the joint inflammatory index. (Smyth)[13, 17] At examination, each set of joints was graded on a 0 to 4+ scale for swelling, tenderness, pain on motion, heat, redness, and limitation. The summation of these pluses established the inflammatory index. No effort was made to compare the efficacy of Indocin to other anti-inflammatory agents.

Arbitrarily, a patient who had subjective improvement defined as a greater than 50% reduction of duration of morning stiffness, a decreased requirement for analgesics and at least a 50% reduction in inflammatory index was considered to have an excellent drug response. A 25% reduction of the inflammatory index, plus some improvement in the other parameters, was considered a good response. Reduction of inflammatory index by only 10% to 15% and some definite improvement in duration of morning stiffness, constituted a fair drug response. Everything else was considered a poor or no response.

RESULTS

Twenty-six patients were treated for an average of 13.7 weeks with Indocin capsules from 75 to 200 mg daily in divided doses. There were 18 female and 8 male patients. Three patients had an inadequate trial. In two of these, the drug was stopped by the patient for no apparent reason; and in one patient, gastrointestinal distress was too severe to continue. One patient reported excellent improvement while taking Indocin. However, the inflammatory character of her disease was not very great and she may have had a spontaneous remission. A good response was observed in 5 patients, while 3 had fair improvement. The remaining 14 had poor or no response to the Indocin trial (Table 2).

Toxic symptoms were common, being present to some degree in 12 of the 26 patients. Headache was present in 8 patients, nausea in 7, and dizziness in 5. One patient complained of constipation, one of abdominal pain and one of partial alopecia. For the most part, the symptoms were mild and tolerable at low to moderate doses (75 to 100 mg) daily. Symptoms were usually more frequent and more severe when an increase in dose was attempted. Complaints of headache, dizziness, and nausea did not abate with prolonged therapy. In only three instances were toxic symptoms of such degree to be an important factor in the discontinuance of the drug. There were no instances of peptic ulcer or gastrointestinal bleeding; nor did any patients complain of psychic disturbances. Blood and urine tests, as previously specified, were monitored at regular intervals on most patients. There was no instance of bone marrow depression; nor was there evidence of liver toxicity or renal irritation.

DISCUSSION

This is a report of a clinical trial of indomethacin only on patients with peripheral rheumatoid arthritis. Evaluation by a single observer eliminated inter-observer variation. No placebo was substituted for the test drug, nor was clinical response compared to another anti-inflammatory agent. An effort was made to quantify inflammation and drug response by employing the inflammatory index described by Smyth. Improvement was observed in about one-third of these patients while on Indocin. Toxic symptoms of headache, dizziness, and gastrointestinal distress due to Indocin were common, but not severe. There were no instances of severe toxic effects such as peptic ulceration, psychic disturbance, hepatic, renal or bone marrow dysfunction. The use of indomethacin did not permit significant and consistent reduction of corticosteroid dose in any of these rheumatoid patients.

The anti-inflammatory effectiveness of indomethacin was reported in experimentally produced inflammation of laboratory animals and in a variety of human rheumatic disorders.[1–10, 16] The impressive clinical reports of Norcross[4] and Rothermich[5]

using Indocin tablets are difficult to interpret because the patient responses were not separated by category or rheumatic disorder and the methods of clinical evaluation were not clear. Of importance, however, was Norcross' observation that it was possible to discontinue or greatly reduce long-term corticosteroid therapy in 11 or 17 rheumatoid patients. This suggested the one value of Indocin might be its "steroid sparing" effect.

On the other hand, Katz, Pearson and Kennedy studied 71 patients with rheumatoid disease and related improvement to that induced by aspirin therapy.[3,8] Three of their patients had almost complete relief of symptoms, while 14 were improved much more than when on aspirin, and 10 had fair improvement or as good as aspirin. The remainder were unimproved. Clark studied 100 patients with peripheral rheumatoid arthritis, 65 of which were receiving corticosteroids.[1] There was improvement of one to two functional classes in 30 of the 100 patients. Thirty-four patients tolerated corticosteroid dose reduction while 31 did not. This suggests a definite, but somewhat less than dramatic anti-inflammatory effect. Catoggio, et al, in a double-blind study, noted "inter and intra patient variability of response," but 66% of patients showed significant improvement.[2]

Recently Smyth[10] reported a detailed study of 55 patients with rheumatoid arthritis treated with indomethacin, paramethasone and placebos over a 32-month period. He followed the inflammatory index, erythrocyte sedimentation rate, ring size, and several functional tests on each patient while taking these agents alternately. A report of percent improvement was not possible because of the method used. Nevertheless, he concluded that indomethacin is a very promising anti-inflammatory agent, but is less effective than corticosteroids. Furthermore, it appeared that two to four months of therapy may be required to attain maximum benefits.

Toxic symptoms, including headache, nausea, vomiting, and dizziness have been generally reported in from 15% to 35% of patients, usually at moderately high doses.[1–4, 8–10] These symptoms are less frequent with the Indocin capsules than with Indocin tablets and less severe at lower doses. Smyth[10] observed that toxic symptoms abate as administration of the drug is prolonged. Gastric or duodenal ulceration was not uncommon in patients taking Indocin.[1,4,9] However, Smyth[10] reported only 2 patients with peptic ulcer of 55 treated with Indocin capsules; one of these was known to have an ulcer prior to its administration.

The data reported here does not support the encouraging initial reports of Norcross[4] or Rothermich.[5] The degree of improvement in patients receiving Indocin reported by Clark[1] or Katz, et al[3,8] may have been induced by the drug, but this improvement could have reflected the natural fluctuation of rheumatoid disease. Conversely, the absence of apparent improvement in the patients reported in this study could be due to the natural course of this capricious disease. Nevertheless, improvement was noted in about one-third of these patients while taking Indocin. This is consistent with the results of Clark,[1] and of Katz, et al.[3,8] In rheumatoid arthritis, only dramatic and repeated improvement while on medication can be confidently attributed to the medication. These data do not permit such a confident conclusion about the efficacy of indomethacin in peripheral rheumatoid arthritis. In contrast to the expected response to corticosteroid agents, Indocin appears to be a variable and unpredictable drug. This is in contrast to the efficacy of indomethacin in ankylosing spondylitis and acute gout according to well documented reports of Smyth, et al.[6,7,9,12] Indomethacin has limited, but probably definite, value in the treatment of peripheral rheumatoid arthritis even as a corticosteroid sparing agent. Further experience will establish the proper place of indomethacin in the management of rheumatoid disease.

SUMMARY

Twenty-six patients with peripheral rheumatoid arthritis were observed clinically for reduction of inflammation in a semi-quantitative manner while on a trial of indomethacin. One had an excellent, 5 had good, 3 fair, and 14 poor response to the drug. Toxicity was minimal. The value of indomethacin in the management of rheumatoid arthritis was not dramatic in this study. These data were compared with that of other clinical observers. The proper place of indomethacin in the management of rheumatoid arthritis requires further careful and standardized clinical observation.

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COMPARATIVE EVALUATION OF TREATMENTS OF ALCOHOL WITHDRAWAL SYNDROMES

THOMAS M. GOLBERT, M.D., CARLOS J. SANZ, M.D., HAROLD D. ROSE, M.D., and THOMAS H. LEITSCHUH, M.D., Wood (Wis.) Veterans Administration Hospital and the Marquette University School of Medicine, Milwaukee:

JAMA 201: 113–116 (July 10) 1967.

Because considerable confusion still seems to be widespread about the choice of drugs in treating alcohol withdrawal, a comparative clinical study was performed to evaluate four therapeutic regimens for these syndromes. These methods of treatment were paraldehyde—chloral hydrate (in combination), alcohol, promazine, and chlordiazepoxide.

All four regimens were evaluated for apparent therapeutic effectiveness in treatment of the tremulous, agitated states and acute hallucinosis. Comparison was based upon failure to prevent delirium tremens and the occurrence of complications (fever without apparent infection, pneumonia, convulsions, death, or combinations thereof) for each group. The results indicate that the group treated with paraldehyde-chloral hydrate had significantly better results and fewer complications than all the other therapeutic programs. Results are summarized in Table 1.

TABLE 1

	Alcohol	Promazine	Chlordiazepoxide	Paraldehyde-chloral Hydrate
Number of patients	12	13	12	12
Improvement without complication	5	5	4	11
Delirium tremens	5	7	6	1* ±
Complications	6	7	10	1 ±

*Significant to $p < 0.01$ compared to other combined results.
±Same patient.

Delirium tremens was treated with either promazine (12 patients) or paraldehyde-chloral hydrate (11 patients). Of those treated with promazine, two died, hallucinations persisted an average of 5.6 days in five, and five were considered therapeutic failures after a mean duration of hallucinations of 4.2 days. In these failures, hallucinations cleared within 48 hours after therapy with paraldehyde-chloral hydrate was initiated. In all patients treated with paraldehyde-chloral hydrate, hallucinations cleared within 24 hours. Eleven patients treated with promazine developed serious complications including fever without infection, pneumonia, convulsions, and death. One complication, fever without apparent infection, occurred among those treated with paraldehyde-chloral hydrate.

This study demonstrated that three of these four regimens should not be used and that the program of paraldehyde-chloral hydrate is the presently indicated treatment of choice.

* * *

TWO UNIVERSITY OF WISCONSIN researchers have linked the psychedelic drug, LSD, with birth defects, according to a copyrighted article in the August issue of McCALL's magazine. The experiments, carried out by Zoology Prof. Robert Auerbach and freshman James Rugowski of Manitowoc, showed gross brain malformations and other defects of the head region in 91 out of 158 embryos whose mother received LSD on the seventh day of pregnancy, the crucial stage at which the brain and other portions of the nervous system are being formed. The article emphasized that the period of maximum risk for a woman occurs about the time a woman is just starting to wonder whether she is really pregnant or only "a little late."

* * *

OF THE 165 VETERANS Administration hospitals, 88 have licenses from the Atomic Energy Commission to use radioisotopes for medical research and clinical treatment.

Therapeutic Dilemmas

No. 2 of a Series

Editor:

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COLUMBIA HOSPITAL, MILWAUKEE

These are recorded reports, which have been edited, of conferences held on Tuesday mornings, 8–9, involving participation by members of the staff of the hospital, interns, residents, and guests. They will be published in a selective manner periodically in the WISCONSIN MEDICAL JOURNAL.

APLASTIC ANEMIA

Moderator: GLENN H. FRANKE, M.D.

Participants: A. JAMES BUTTLES, M.D.
JOHN O. CHAMBERLAIN, M.D.
D. B. CLAUDON, M.D.
EFSTATHIOS BELTAOS, M.D.
ANTHONY V. PISCIOTTA, M.D.

Dr. Glenn H. Franke: For the conference this morning we are fortunate in having two cases that strikingly illustrate the contrasting features of distinctly differing types of aplastic anemia. Doctor Buttles, will you kindly present the first case?

Dr. A. James Buttles (Resident in Medicine): The patient, a 30-year-old white woman, gravida IV, para IV, was admitted for study of her "anemia." She was extremely pale, but not jaundiced. Blood pressure 110/70 mm Hg, pulse rate 100, temperature 98.6 F. Pallid mucous membranes of nose and throat. No cervical adenopathy. Thyroid, slightly enlarged and soft. Lungs, clear. Heart, regular rhythm; grade II systolic murmur at apex. Abdomen, soft; liver and spleen not palpable. There were no purpuric or ecchymotic areas on the skin. Bleeding time, 2 minutes. Lee–White coagulation time, 7 minutes. BUN, 16 mg/100 ml. E.S.R. 35 mm/hour. Coombs test, negative. Serum protein electrophoresis, normal. Total bilirubin, 0.8 mg/100 ml. Hematocrit 32 ml/100 ml. Serum iron, 205 micrograms/100 ml (total iron-binding capacity, 358 micrograms/100 ml; unsaturated iron-binding capacity, 103 micrograms/100 ml [% saturation, 57]). Peripheral blood: "pancytopenia with slight reticulocytosis." Bone marrow: "aplastic."

There was history of an upper respiratory tract infection in the spring of 1966, which was treated with an unknown drug. In December 1966 there was an attack of bronchitis and a diagnosis of anemia; therapy, iron, and another drug that may have been demethylchlortetracycline (Declomycin). Other drug history: no chloramphenicol (Chloromycetin), diphenylhydantoin (Dilantin) or mephenytoin (Mesantoin); no exposure to solvents. Menses have been regular, without excessive bleeding. The hematologic course while under observation in this hospital is shown in Table 1. The patient was sent home on methyltestosterone, 10 mg sublingually 3 times daily; prednisone (Meticorten), 60 mg daily; magnesium and aluminum hydroxides (Maalox), and phenobarbital. Presently her main complaint is that her face is feeling "very tight."

Doctor Franke: This is my patient and I would like to amplify the record in two respects. First, she was placed on iron therapy empirically while waiting the two or three

TABLE 1—*Hematologic course while in hospital*

	12/5	1/9	1/26	1/28	1/30	2/2	2/4	2/9
Hgb	9.5 gm.	8.4	7.2	6.3	6.6	6.6	9.8	10.4
Hct	28%	26	20	19	20	19	29	30
WBC	5,550			2,850	4,510	2,754	4,555	4,150
Non segs.	0			4	1		6	0
Segs	40			14	13		38	37
Lymphs	60			80	80		53	63
Monos	0			1	6		3	0
Eos	0			1	0		0	0
Hypochromia	Sl			Sl				Sl
Anisocytosis	Sl				Sl		Sl	Sl
Poikilocytosis	Sl				Sl			
Platelets					16,000			57,000
RBC					1,850,000		2,780,000	
Retic					2.1%			

weeks for a hospital bed, and during this time the hemoglobin dropped from 9.5 to 7.5 gm. But she felt well, though admitting decreased exercise tolerance. Actually we had to talk her out of a skiing expedition. Now, Doctor Chamberlain will present his case, which is one of pancytopenia of another type.

Dr. John O. Chamberlain: I was asked to mention this case only a few minutes ago and as a result am not prepared to make as full a presentation as is warranted. This 75-year-old gentleman is in the hospital currently, being admitted on this occasion—after several operations in the past for malignancy of the colon—because of demonstration of an apparently enlarging colon polyp. He had a normal hemogram prior to surgery. He was operated upon, having an anterior resection and two colotomies. After a reasonably satisfactory immediate postoperative course, he developed a small bowel obstruction and was re-operated. At this time there was felt to have been a spill into the peritoneal cavity, and multiple drug therapy was begun. When he began to bleed catastrophically, he was being treated with penicillin, cephalothin (Keflin), colistin (Coly-Mycin) and chloramphenicol (Chloromycetin). This profuse bleeding occurred over one weekend. There was bleeding from the wound sites, marked rectal bleeding, etc., and he required almost constant blood transfusion to maintain him. The hematologic studies showed at that time, in addition to the anemia, some increase in fibrinolysin activity and decrease in platelets.

It was felt that chloramphenicol was probably the drug in the causative role in this occurrence. In therapy we used the fibrinolysin antagonist, aminocaproic acid (Amicar), transfusions and platelet infusions, as well as corticosteroids; and the bleeding stopped. The patient still has multiple abdominal fistulas and wound infections, but the surgeon anticipates an ultimate favorable outcome. I believe the bone marrow presently shows some improvement.

Doctor Franke: Doctor Beltaos, would you like to enlarge upon the bone marrow picture in this case?

Dr. Efstathios Beltaos (Department of Laboratories): The first bone marrow showed an increase in the megakaryocytes, but almost all of them produced platelets poorly. The second marrow examination, performed about a week later, showed megakaryocytes producing platelets normally; on this basis we think that there is definite improvement.

A Physician: The platelet count was originally about 55,000, I believe. What is it now?

A Physician: Did you stop administration of all the antibiotics or only chloramphenicol?

Doctor Chamberlain: The present platelet count is about 270,000. Originally all antibiotics were stopped except penicillin; then, because of the considerable infection of wound sites and the general sepsis, the use of cephalothin (Keflin) was resumed in addition. Both these agents are being continued without any obvious ill effects.

Doctor Franke: Since aplastic anemia is not a commonly encountered disease, we were somewhat puzzled by the first case, that of the young woman. Was this aplastic anemia or was it an aleukemic phase of leukemia? The original bone marrow and peripheral blood smears were not really clear-cut. Doctor Claudon, you are familiar with this case; do you care to add anything?

Dr. D. B. Claudon (Department of Laboratories): The only thing I have to add is the seeming discrepancy of a higher-than-normal reticulocyte count; but I imagine that Doctor Pisciotta will comment upon this.

Doctor Franke: Doctor Beltaos will now show the more significant of the bone marrow slides in this case.

Doctor Beltaos: Figure 1 is a small magnification of a bone marrow smear. It has very few marrow cells; at this magnification you cannot say what they are, but most of them were reticuloendothelial cells. This very hypocellular appearance of the marrow was not due to dilution by blood because when we repeated it the following day it looked the same, and after screening quite a few smears and imprints, we found some bone marrow flecks. Figure 2 is a photograph of one of these flecks. Apart from reticuloendothelial cells and a few lymphocytes and plasma cells, no other kinds of cells were found. Our diagnosis then was aplastic anemia affecting all series of cells of the marrow because, as you know, it can affect one series, any combination of two, or all three of them.

Doctor Claudon: One feature that Doctor Beltaos inadvertently failed to mention was the abnormal number of mast cells scattered through the marrow. Doctor Pisciotta will

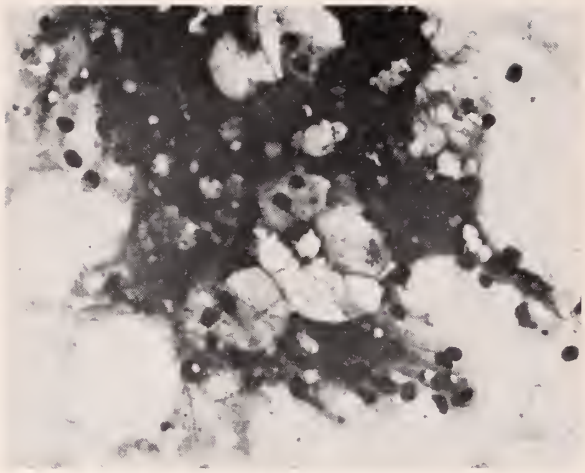

Fig. 1—One of the rare bone marrow flecks found in a direct smear preparation.

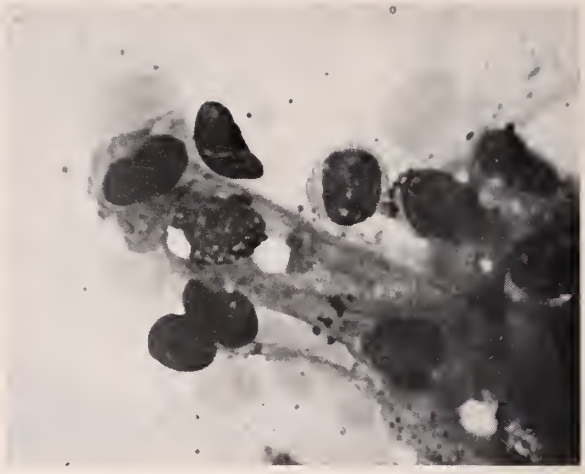

Fig. 2—At higher magnification it can be seen that almost all cells are reticuloendothelial.

probably comment upon this rather unusual finding also.

Doctor Franke: Doctor Pisciotta, who is, as you all know, Professor of Medicine at Marquette University School of Medicine and Director of the Blood Research Laboratory at Milwaukee County General Hospital, as well as being a member of our own Consulting Staff, has seen both these patients and has kindly offered to discuss this morning the subject of aplastic anemia in general.

Dr. Anthony V. Pisciotta: These two cases contrast two kinds of bone marrow depression. The first, Doctor Franke's patient, appears to have a pancytopenia of a chronic or permanent nature; the second, Doctor Chamberlain's patient, represents temporary depression of one of the bone marrow elements that was reversed when the suspected drug was discontinued and possibly by treatment with corticosteroids, while platelet concentrate suspensions were given to stop the bleeding.

In the differential diagnosis of pancytopenia, one must consider the possibility of aleukemic leukemia. Sometimes such a leukemia will become manifest after splenectomy, but often the patient will have to be followed for several years before the diagnosis becomes apparent. In preleukemia the marrow is usually crowded with cells, although their type may not be diagnostic; in Doctor Franke's young woman, however, the bone marrow was relatively devoid of cells, with relative increase in fat spaces.

Pancytopenia may also be seen in disseminated tuberculosis; here too the marrow should be hyperplastic and the patient is often febrile. Furthermore, in disseminated tuberculosis, despite leukopenia, there is usually a relative increase in the percentage of segmented and stab forms, an increase in the percentage of monocytes and decrease in percentage of lymphocytes. We did not see this kind of formula in this patient.

Another disorder to consider is disseminated lupus erythematosus, especially in a young woman such as this. But she had none of the findings proper to this malady; she was asymptomatic despite the anemia—she had no arthralgia, no fever, no bone marrow hypercellularity that one would expect in lupus erythematosus.

Pancytopenia might also occur where there is nutritional deficiency, such as vitamin B_{12} or folic acid. In such a case there is a megaloblastic bone marrow; and the megalocytes, macrocytes and hypersegmented polys characteristic of vitamin B_{12} or folate deficiency would show up in the peripheral blood. Absence of these findings in our patient ruled out lupus erythematosus. Since the marrow contained tissue mast cells, lymphocytes and reticulum cells, and very few cells overall, we felt that the diagnosis of aplastic anemia was justified.

Does reticulocytosis rule out aplastic anemia? I do not think so. Perhaps the patient has been removed from whatever noxious influence she had been exposed to and is now undergoing spontaneous remission. This may be manifested both by the reticulocytosis and the fact that her hemoglobin values have been maintained for the past three weeks without transfusion. I suppose reticulocytosis is possible in the event of spon-

taneous recovery, at least I have no other explanation.

The significance of the tissue mast cells in pathologic bone marrow is not clear. They often occur thus in aplastic anemia, in chronic lymphocytic leukemia, during recovery from agranulocytosis, and in a few other pathologic states.

The puzzling feature of this first case is the matter of etiology. We do not know what the first antibiotic given her might have been. Confronted with capsules of chloramphenicol, she denied having seen them before, but said that the first drug was a red pill. This suggested demethylchlortetracycline (Declomycin) of course, but we cannot be sure. She also denied dry-cleaning her own clothes, exposure to x-ray, or other sources of marrow depression. About half of the clinically encountered cases of aplastic anemia have no definite etiology.

Treatment has been conventional; transfusion to a comfortable level of hemoglobin, corticosteroids and testosterone. Unfortunately, this combination of drugs, the best we have, is likely to alter the appearance of this attractive young woman. It may be possible to reduce dosage later on or even discontinue drugs altogether if adequate hematologic remission is sustained.

Several other types of treatment are available. Scott, Cartwright and Wintrobe (Acquired Aplastic Anemia: An Analysis of Thirty-nine Cases and Review of the Pertinent Literature, Medicine 38:119, 1959) attributed prolonged survival to splenectomy in a large series of cases. Humble, in Great Britain, (The Treatment of Aplastic Anemia with Phytohemagglutinin, Lancet 1:1345, 1964) used phytohemagglutinin, extracted from beans, intravenously with some effect in four patients, but others have not confirmed this. I found in two cases that the only thing accomplished was to induce chills and fever. Bone marrow transplantation is usually unsuccessful because the same barrier exists as in the case of transplanting organs and skin. The recipient rejects the introduced cells unless previously prepared (i.e., elimination of his own histocompatability antigens) by irradiation or use of a drug such as 6-mercaptopurine. He may then accept the marrow cells, only to have them incite production of antibodies against the host, and we then have a clinical form of runting disease.

Mathe, in Paris, (Mathe, G., Amiel, J. L. and Schwarzenberg, L.: L'aplasie Myelolymphoide de L'irradiation Totale. Gauthier–Villars, Paris, 1965) used a cocktail of marrows from many individuals, hoping that one family of them might prove compatible. Unfortunately the findings have not been confirmed on a practical therapeutic level.

Half of the patients with aplastic anemia do not have a demonstrable etiologic agent in their background, and the young woman we are presently considering exemplifies this group. In the other half, benzol and irradiation have both been superseded in the causative role by synthetic drugs in recent years. And of all the drugs, chloramphenicol is responsible for the greatest number of cases. The first report of such an occurrence actually was made from this hospital by Doctors Claudon and Holbrook, (Fatal Aplastic Anemia Associated with Chloramphenicol Therapy—Report of Two Cases, J.A.M.A. 149:912, 1952). If you give chloramphenicol in high enough dosage, there will be evidence of bone marrow damage in most individuals; but permanent, irreversible aplastic anemia is a rare occurrence. Estimates of its incidence run from 1 in 100,000 to 1 in 300,000 exposed persons. (Leiken, S. L., Welch, H. and Guin, G.: Aplastic Anemia due to Chloramphenicol, Clin. Proc. Children's Hosp. Wash. D. C. 17:171, 1961.)

In the universal type of bone marrow depression caused by the drug, as exemplified by Doctor Chamberlain's patient, the elderly man, recovery is the rule. Keep the patient out of trouble while the bone marrow is depressed, and he will get better. But the aplastic anemia is usually fatal. Aplastic anemia shows a predilection for young people, especially women, and there is no definite pattern of drug usage in these cases. Some patients develop the malady after very small amounts, some after large amounts over a long period, some after intermittent dosage, and some only months after the drug has been discontinued. By contrast, the universal type of marrow depression from the drug usually results from high dosage, actually not less than 7 gm continued throughout 20 weeks or more.

Recently I interested myself in determining why the drug was given to the more than 300 patients whose records of chloramphenicol-induced aplastic anemia are in the files of the Committee on Drug Reaction of

the American Medical Association, in Chicago. In the time available I was able to study only 144 case records, but in these I found that the reason for administration was not stated in 49 instances; that there had been only mild or no infection at all in 80 instances (mild earache, upper respiratory infection, vaginal discharge, something of mild nature); and that there had been severe infections in only 15 instances.

Numerous attempts are being made to determine the nature of chloramphenicol's depression of the bone marrow and whether the universal depression (Doctor Chamberlain's patient) is merely a preliminary phase of aplastic anemia (Doctor Franke's patient). Doctor Weisberger, (Weisberger, A. S. and Wolfe, S.: Effect of Chloramphenicol on Protein Synthesis, Fed. Proc. 23:976, 1964) whose brilliant presentations here at this hospital and at the Academy of Medicine last year you all remember, feels that the drug interposes a block between messenger RNA and the ribosomes so that protein synthesis is prevented; but he does not feel able to determine from his observations whether this is the explanation of the induced aplastic anemia or merely of the universal bone marrow depression. Yunis and Harrington (Yunis, A. A. and Harrington, W. J.: Patterns of Inhibition by Chloramphenicol of Nucleic Acid Synthesis in Human Bone Marrow and Leukemic Cells, J. Lab. Clin. Med. 56:831, 1960) studied the possible dose-related effect in the reaction and have been able to show at least that incubated bone marrow cells from individuals who have had chloramphenicol-induced aplastic anemia are sensitive to lower concentrations of the drug than are specimens from other individuals.

In some of my own studies, as yet unpublished, I have proceeded on the assumption that, since aplastic anemia is due to a failure of cell division, it is likely that chloramphenicol exerts a deleterious effect upon such division. Indeed, I have found that it does definitely and significantly suppress the accumulation of mitotic figures of phytohemagglutinin-stimulated cultures of peripheral blood cells, although it has no effect upon DNA synthesis or the incorporation of thymidine into intact cells. And at the University of Chicago, Taylor has found that the elaboration of the mitotic spindle protein is prevented by the drug. Although definitive answers are not yet available, continuing studies promise to provide us with more definitive information in this vexing problem.

Doctor Franke (summarizing): Thank you, Doctor Pisciotta. This morning we have had the two contrasting types of aplastic anemia presented in actual cases and the significant aspects of the subject thoroughly discussed.

CORRECTION

In the first article of this series printed in the July issue at page 304 and entitled "Complicated Hashimoto's Thyroiditis", the name of James M. Cerletty, M.D. was inadvertently omitted from the list of participants in the Grand Rounds. Our apologies to Doctor Cerletty.—EDITORS

TETANUS STILL A THREAT

Tetanus is still a threat, according to two University of Wisconsin surgeons.

Despite continuing campaigns for immunization against tetanus, only small segments of the population have been immunized, say Drs. Louis C. Bernhardt and Robert C. Hickey in a recent issue of the AMERICAN JOURNAL OF SURGERY.

"Children, young adults, and United States armed forces veterans are among those immunized," Doctors Bernhardt and Hickey explain. "Many middle-aged and elderly persons, however, have neglected this or have failed to maintain their immunization."

Fifty-five per cent of Wisconsin's tetanus cases occurred after farm injuries, the doctors point out. These injuries include puncture wounds of the feet, barnyard abrasions, and accidents with farm equipment.

"Mortality from untreated tetanus infections is between 90 and 100 per cent," the researchers report. They urge tetanus toxoid immunization for all persons, and care in maintaining protection with booster injections.

Basic immunization usually consists of three injections during a three-week period, followed by a booster injection six months to a year later.

A booster should be given every five to six years thereafter to insure protection against tetanus, Doctors Bernhardt and Hickey explain. Many persons forget this, they add, and tetanus infection can develop in the partly protected person.

* * *

THE NUMBER OF veterans hospitalized for strokes and brain damage accompanying aging has more than doubled in eight years, according to the Veterans Administration.

Presented by the Wisconsin Society of Pathologists
S. L. Inhorn, M.D., Madison, Chairman of the Publications Committee

Myocardiopathy and Other Associated Nonneurological Manifestations in Friedreich's Ataxia

By CARL J. CHELIUS, M.D., JOHN RENNICK
and ROCCO LATORRACA, M.D., Cudahy, Wisconsin

■ FRIEDREICH'S ATAXIA as originally described was considered a heritable, degenerative disease of the nervous system, with a mean age of onset of 7 years and a mean age of death, 29 years, manifesting itself clinically with ataxia, absence of deep tendon reflexes, presence of a Babinski sign, dysarthria, and associated skeletal deformities, most commonly kyphoscoliosis and pes cavus. The anatomic basis of the neurologic symptoms is an atrophy of the spinal cord, posterior nerve roots, and the tracts of Goll and Burdach, with varying demyelinization of the spinocerebellar tracts, pyramidal tracts, fasiculus gracilis, fasiculus cuneatus, and Clarke's columns. Demyelinization of the posterior nerve roots is also described. Varying degeneration of the gray matter of the cord may occur. A reactive, intense glosis is present in the affected areas. Involvement may reach the upper cord, the medulla, and cerebellum.

Although not stressed, the cardiac abnormalities have been associated with the disease as early as Friedreich's original report, in which five of the six cases described showed clinical cardiac abnormalities and two of the three cases going to autopsy had myocardial damage.[1] It was Pitt, in 1887,[2] and Saury, in 1905,[3] who first emphasized the association of the cardiac abnormalities with Friedreich's ataxia. Since then, Manning[4] reported that 30% of the patients with the disease showed cardiac changes, and Boyer et al[5] reported that 55% of their patients with Friedreich's ataxia had definite evidence of heart disease. The indication is that cardiac abnormalities are quite common, if not constant findings among affected patients, as documented by Hartman and Booth.[6]

Usually, there are no outward or noticeable signs of cardiac abnormality at the first manifestation of the disease. However, in several cases reported by Novick[7] and Thilenius et al,[8] cardiac symptoms brought the patient to the clinic, and upon further examination the Friedreich's disease was discovered.

It has been possible to diagnose these cardiac abnormalities early, by the use of electrocardiography. In 1929, Mollaret[9] was the first to describe the electrocardiographic abnormalities; since then, electrocardiograms have been used extensively in the study of patients with Friedreich's disease. In 1950, Flipse et al,[10] divided the electrocardiographic abnormalities into two groups, the first involving disturbances in impulse initiation and transmission, including paroxysmal atrial tachycardia, ventricular tachycardia, atrial fibrillation, atrial flutters, and bundle branch blocks. The second group includes changes associated with alterations in the ventricular complex, such as slurring or low voltage of the QRS, deep Q waves, elevation or depression of the ST segment, isoelectric, diphasic or inverted T waves in one or more leads. It should be noted, however, that in children inversion of T waves in leads V_1, V_2, V_3, and V_4 is normal, but that inversion in leads V_5 and V_6 is abnormal and suggests ischemia of the left ventricle.[11]

Diabetes mellitus is a metabolic disorder that is associated with Friedreich's disease with greater frequency than can be attributed to chance alone.[12-14] Rossi first reported two cases associated with Friedreich's

From the Medicine and Pathology Departments of Trinity Memorial Hospital, Cudahy.
Doctor Chelius is Assistant Clinical Professor of Medicine; Doctor Latorraca is Assistant Professor of Pathology; and Mr. Rennick is a Sophomore medical student, all of Marquette University School of Medicine, Milwaukee.

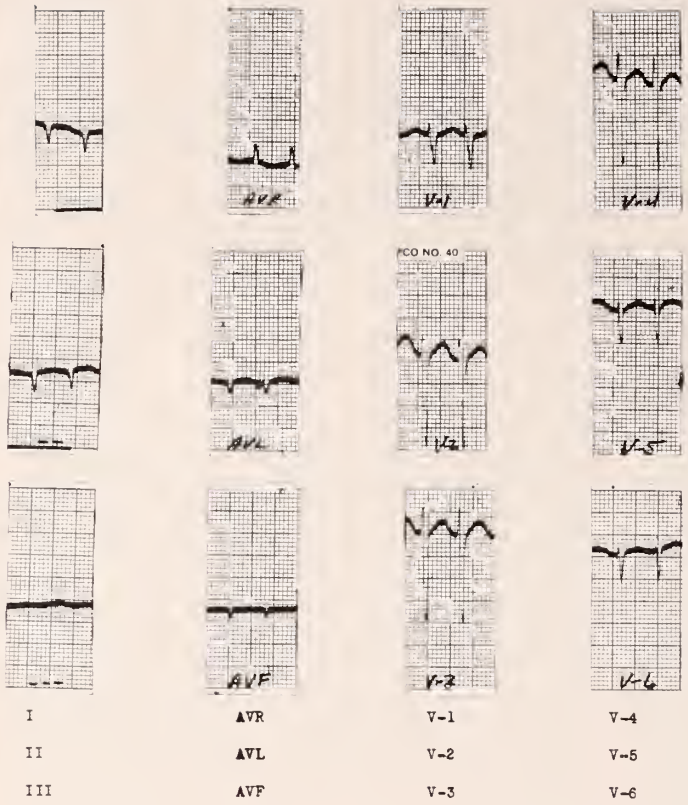

Fig. 1—(Case 2) Electrocardiogram on admission Mar. 13, 1961, shows supraventricular tachycardia, nonspecific ST–T wave changes, persistance of deep S waves in the left precordial leads, and QS patterns in leads I, II, III, AVL and AVF.

disease in 1893, and the relationship was mentioned by Guillain and Mollaret in 1932,[15] but it was not until 1940 that the significance of such an association was suggested in the report of Schlesinger and Goldstein.[14]

Another commonly reported clinical manifestation leading to metabolic disturbance is severe, unexplained vomiting, warranting medical measures for control and occasionally contributing to the death of the patient.[9,16-18]

A solitary case of diabetes insipidus combined with Friedreich's disease was reported. (Friedreich's case, Charlotte Losch).

The present report is prompted by the study of a family of four afflicted siblings; three have manifested heart disorder and two developed diabetes mellitus prior to death. Autopsies were performed on three siblings. (A summary in table form similar to the report by Evans and Wright[19] and additional references not cited here are available on request to the authors.)

CASE REPORTS

The father is 53 years old and has no family hi tory of Friedreich's ataxia. His paternal gran father had diabetes mellitus. Routine electrocardi grams in 1961 and 1966 were normal. The mothe 52 years old, also has a negative family histor Her electrocardiograms in 1961 and 1966 were no mal. Neither parent has had serious illnesses.

Case 1—The oldest child, a girl, had the onset o Friedreich's ataxia at the age of 8 years. At 2 years of age she became acutely ill with nausea vomiting, and drowsiness and was admitted to local emergency hospital where the diagnosis o diabetic coma was made. She had a history of re cent onset of polydipsia, polyuria, and weight los Physical examination of the heart was said to b essentially normal. Blood pressure was not obtain able. The feet showed bilateral equinovarus de formities. Deep tendon reflexes were absent. Th clinical diagnosis was coma and acidosis due t diabetes mellitus, along with Friedreich's ataxia She was treated for shock and acidosis, but did no respond to therapy and subsequently died. An elec trocardiogram was not obtained.

At autopsy, the heart weighed 210 gm. The lef ventricular wall averaged 12 mm and the right ven tricular wall 3 mm in thickness. The valves an major vessels were normal. The myocardium wa dull red and flabby. The microscopic findings in th tissue available to us included the presence of a fe focal areas of fibrous thickening of the endocardiun and a slight hypertrophy of some of the myocardia fibers. In summary, this was a 25 year old woma with Friedreich's ataxia since age 8, who died i diabetic coma.

Case 2—A second child, a boy, was seen at th age of 13 years, in 1956. He apparently had th onset of Friedreich's ataxia at the age of 9. In 1958 he developed a febrile disease, with joint pains. C reactive protein was 1 plus, the antistreptolysin titer was 1:160, and betahemolytic streptococci were cultured from the throat. He received adequate treatment and had no further symptoms. By 1959 he was restricted to a wheelchair and had developed severe kyphoscoliosis. On Mar. 13, 1961, he was first seen by this examiner (C. C.) in the emergency room of the hospital, at which time he complained of difficulty in breathing and of substernal pain. He was hypotensive and an immediate electrocardiogram showed a supraventricular tachycardia, ST-T changes, and changes that possibly indicated posterior wall myocardial infarction (Fig 1).

The patient received lanatoside C (Cedilanid) and phenylephrine hydrochloride (Neo-Synephrine) intravenously to stop the tachycardia. No heart murmur was audible. Laboratory studies showed a normal serum glutamic oxaloacetic transaminase, but the lactic dehydrogenase was elevated to 800, 940, 1020, 440, and 280 units on successive days. The heart rate continued to be rapid until steroids and quinidine were added. His heart rate decreased,

nd the cardiac rhythm changed to a wandering acemaker with premature contractions. His chest ain, which responded to nitroglycerine, had subded; and he was released on Mar. 20, 1961. On ischarge his electrocardiogram showed normal nus rhythm.

Two other admissions for substernal pain and achycardia occurred in April and May of 1961. oth started after episodes of vomiting and diarhea. During these admissions, he was given potasum intravenously, since it was felt that electrote depletion could trigger his arrhythmias, lthough serum electrolyte values were normal. He ot along fairly well until July 14, 1961, when he as seen at home, after an episode of numbness nd paralysis of the right extremities. When exmined, he had completely recovered and there were o residual neurologic signs. Several days later he eveloped diarrhea, which responded to oral edications.

On July 24, 1961, he developed petechiae, and the uinidine was discontinued. The same afternoon, he ollapsed at home and was brought to the emerency room of the hospital. On admission he was thargic and semi-comatose and had a right hemiaresis. He responded to loud verbal stimuli. The eart was irregular with a pulse rate of 86 to 90 eats per min; no murmur was present. Blood presure was 130/75 mm Hg. He had multiple petechiae nd subcutaneous ecchymoses, but Rumple-Leed's est was negative. There was a constant horizontal ystagmus. A half hour later, he was able to move ll four extremities. At 7:30 PM he was alert, concious, able to move freely, and to talk. At 9:00 PM e developed a generalized convulsion, followed by he onset of Cheyne-Stokes respirations. A spinal ap revealed clear cerebrospinal fluid. The patient id not regain consciousness, and he succumbed at 2:45 PM on July 26. The last electrocardiographic racing taken on the day of his death showed lefinite atrial fibrillation with ectopic ventricular ontractions (Fig 2).

At autopsy the heart weighed 640 gm. All chamers were enlarged and hypertrophied. All valves vere free of disease as were chordae tendinae and apillary muscle. The right ventricle measured 7 nm in thickness. The thickness of the left ventricle vas 20 mm. On multiple section the myocardium vas light brown and firm, but no gross scars were oted. No necrosis was found. The coronary arteries ad smooth intimal linings, and were free of demontrable arteriosclerotic plaques. The aorta was pened along its entire length, and no coarctation r other anomaly was found.

The histologic examination of the heart revealed narked changes in the myocardium. The myocardial ibers were large and hypertrophied in most areas, xcept in a few subendocardial areas. In many fields he fibers were separated one from the other by a oose fibrous tissue containing a few fusiform cells resembling fibrocytes. Elsewhere there were also small collections of plasma cells and lymphocytes,

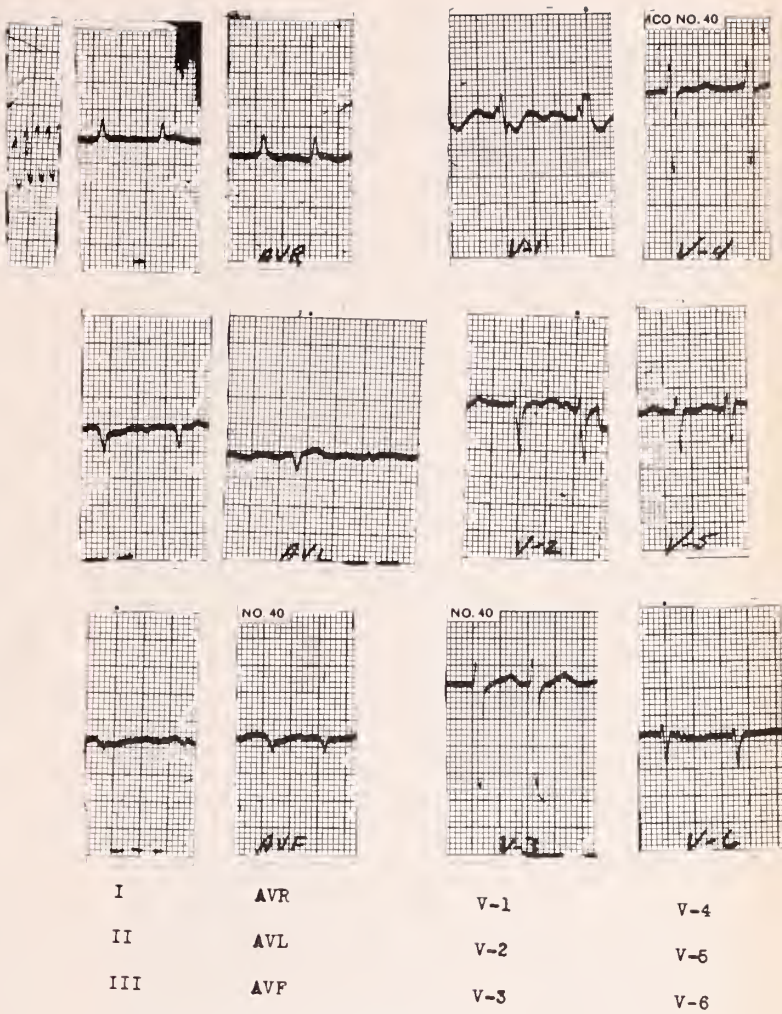

Fig. 2—(Case 2) Electracardiagram taken on the day of his death shaws atrial fibrillatian.

with an occasional neutrophil. Varying fibrous tissue deposits were noted between muscle fibers, and they also replaced lost individual muscle fibers. Some myocardial fibers showed complete loss of cross striations and were eosinophilic and hyalin. Many of the myocardial fibers contained large hyperchromatic nuclei, some irregularly shaped. The glycogen stains of the myocardial cells were negative. No fat could be demonstrated with fat stains; lipochrome pigment was present adjacent to nuclei in many of the fibers. The endocardium was normal. Examination of the blood vessels throughout the body failed to reveal any evidence of vasculitis, either acute or healed. No evidence of platelet thrombi in the capillaries were noted.

In summary, there was hypertrophy of the myocardium with patchy interstitial fibrosis, degeneration, and loss of myocardial fibers, with only minimal and negligible areas of chronic nonspecific myocarditis (Fig 3).

Case 3—The second oldest child, a girl, was born in 1940 and had the onset of Friedreich's ataxia at

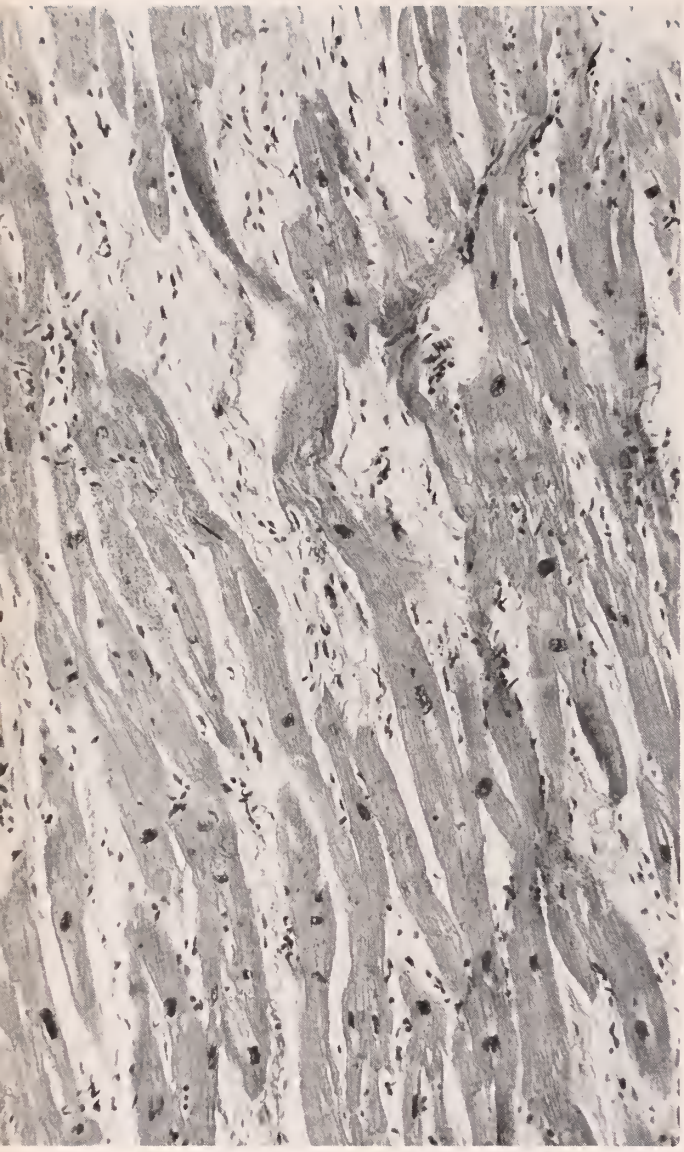

Fig. 3—(Case 2) Low-power view shows patchy interstitial fibrosis hypertrophy of myocardial fibers, and separation of myocardial fibers by increased interstitial tissue.

the age of 8 years. An electroencephalographic examination was performed in 1956 and was reported as "abnormal EEG with diffuse pathology" because of frequent diffuse irregular bursts of high voltage slow waves mingled with slow spikes in wake and sleep, most prominent in the frontal and temporal regions.

An electrocardiogram done after her brother's death in 1961 showed nonspecific T changes especially over the posterior inferior area (Fig 4). On Dec. 14, 1962, she was seen at home complaining of headache, nausea, and a cough. The heart was irregular with premature contractions. A few days later she had a regular apical rate and the electrocardiogram showed similar nonspecific T wave changes.

In February of 1963 an irregular apical rate was again noted. She was admitted to the hospital on Mar. 27, 1964, with an acute arrhythmia. A history of spells of drowsiness and a "feeling like fainting" during the week prior to admission was obtained. During an emotional disturbance on the afternoon of admission, she became pale and developed an oppressive feeling in her midchest. Her blood pressure was 60/50 mm Hg, and the apical rate was more than 100 per minute. After an electrocardiogram showed rapid atrial fibrillation, she was given 4 ml of lanatoside C intravenously and 0.1 mg of phenylephrine intravenously and oxygen, and she converted to a sinus rhythm with wandering pacemaker. Her blood pressure rose above 100 mm Hg systolic.

A chest x-ray film was normal. Her respiration was irregular. Two days after admission muscular twitching and spasm developed.

She received intravenous fluids, cortisone acetate, hydrocortisone 21-sodium succinate (Solu-Cortef), and antibiotics when the temperature rose to 101 F and 102 F, as a desperate effort to save her life. She died on Mar. 30, 1964, although in good electrolyte balance. Preterminally she developed petechiae over her arms and trunk, Cheyne-Stokes respiration, and a presystolic gallop rhythm.

The laboratory findings of significance included, on admission, blood sugar of 130 mg per 100 ml (nor-

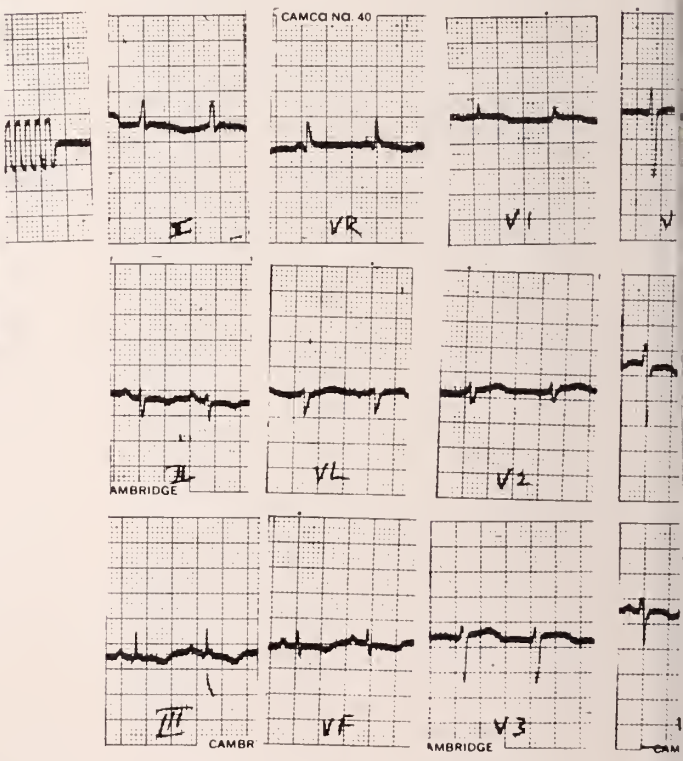

Fig. 4—(Case 3) Routine electracardiogram, taken at the time of her brother's death, shows persistance of deep S waves aver the left precordium with on R wave in Lead V_1 and nonspecific T inversions in leods II, III, AVF, and V_5 and V_6.

mal range, 60 to 90, by the Nelson–Somogyi method), an elevated serum glutamic oxaloacetic transaminase of 63 units, and an elevated white blood cell count of 21,600 per cu mm, with 2 stab forms, 94 segmented neutrophils, and 4 lymphocytes. After being elevated for two days, the blood sugar returned to a normal value of 73 mg per 100 ml following insulin administration. The serum glutamic oxaloacetic transaminase rose progressively to 2,090 units. The prothrombin time on Mar. 30, 1964, was 15% of normal. She had a 4+ urine sugar on admission and repeatedly thereafter.

Autopsy revealed that the heart weighed 340 gm. The right auricular appendage had an ante-mortem blood clot which was bright red, laminated, and loosely adherent to the auricular wall. The right ventricle was dilated and the endocardium was pale tan. The left ventricle was dilated. The coronary ostia and the coronary arteries were unremarkable and free of atheromatous plaques. The aorta was well formed, with only minimal yellow atheromatous streaking noted in the intima. All valves, chordae tendinae, and papillary muscle were normal.

Histologically the heart showed the epicardial tissue to be thickened by fibrosis, but no inflammatory cells were present. The most striking change was in the myocardium. All sections, including those through the atrial and ventricular wall, had essentially the same findings; namely hypertrophy of the myocardial fibers. The fibers were intact, with central large lobulated nucleus. The cross striations were preserved, with only occasional vacuolization of the cytoplasm of the fiber noted. Loose fibrous tissue was present throughout the myocardium, more abundant in some areas than in others. The fibrous tissue enveloped bundles as well as isolated myocardial fibers. Some of the isolated fibers so enveloped were very thin in comparison to adjacent fibers which were hypertrophied. Within the loose fibrous tissue, there were fusiform fibrocytes and oval cells resembling lymphocytes. Rare neutrophils were present. The endocardium was essentially unremarkable. There was no evidence of vasculitis or other vessel disease in the myocardium, nor of infarction, acute or old.

All endocrine glands were normal.

In summary, there was fibrosis of the interstitium and hypertrophy of the myocardial fibers with focal collections of minimal inflammatory infiltrates (Fig 5).

Case 4—The youngest sibling, born in 1948, was diagnosed as having Friedreich's ataxia at age 7 years. She had several accidental falls. In 1958 she had an abnormal electroencephalogram similar to her older sisters, and an electrocardiogram in 1961 showed low voltage in the standard and unipolar limb leads with definite but nonspecific T wave changes.

In October 1965 she was seen at home after an acute emotional upset. Her blood pressure was 130/80 mm Hg and she had definite premature contractions. An electrocardiogram four days later revealed no irregularity but a sinus tachycardia with a rate of 105 per minute. There was right axis deviation and nonspecific T wave changes. The low voltage in the standard and unipolar limb leads was maintained. A glucose tolerance test showed a definite diminished tolerance.

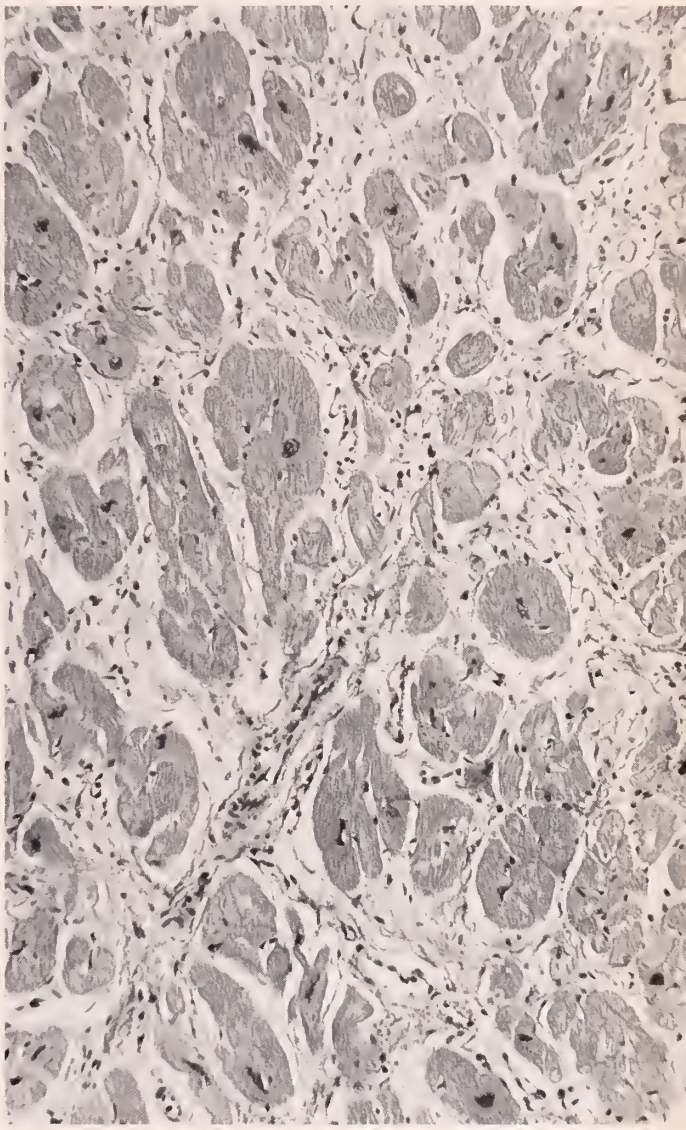

Fig. 5—(Case 3) This demonstrates the marked hypertrophy of the myocardial fibers, the separation of the fibers by loose connective tissue, and few lymphocytes in the interstitium.

She was hospitalized for two days in January, 1966 after having been seen at home because of extreme weakness, pallor, rapid respirations, and perspiration. This occurred after an argument with a girl friend during a telephone conversation. When examined, she was anxious, pale, dyspneic, and tachypneic and her apical rate was irregular and over 200 beats per min. There was no heart murmur. The lungs were clear. Her blood pressure was 90/70 mm Hg.

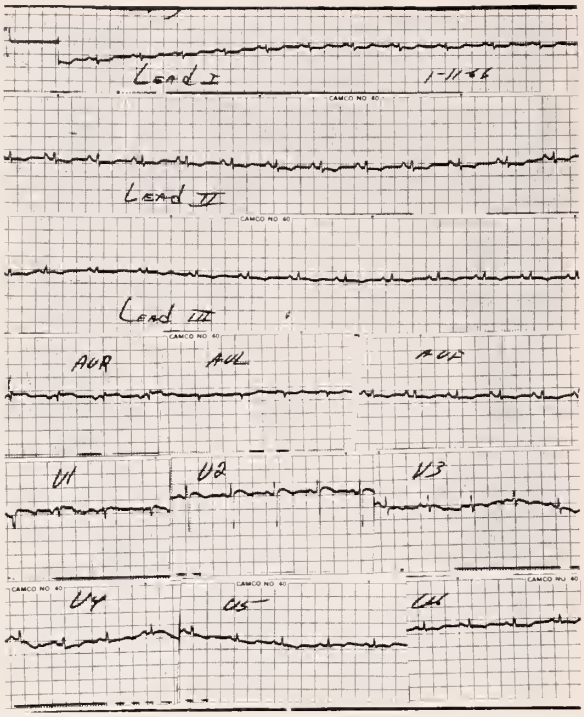

Fig. 6—(Case 4) Cardiogram taken on Jan. 11, 1966 shows ST segment depressions in leads I, III, AVF and V_{4-6}. T waves are inverted in leads II, III, AVF and V_2 through V_6.

Four milliliters of lanatoside C given intravenously resulted in conversion to a regular rate of 90 beats per min shortly. The electrocardiograms during this hospitalization showed T wave inversions in leads II, III, AVF, V_2 to V_6. The ST segments were depressed in leads I, III, AVF, V_4 through V_6 (Fig 6). The white blood cell count was 16,400 per cu mm with 2 stab forms, 79 segmented neutrophils, 17 lymphocytes, and 2 monocytes present in the differential count. The serum glutamic oxaloacetic transaminase, hydroxybutyric dehydrogenase, and lactic acid dehydrogenase were normal. She was discharged on maintenance therapy of 0.5 gm of tolbutamide and a rauwolfia serpentina preparation.

DISCUSSION

The older daughter (Case 1) of this family who died of diabetic acidosis did not exhibit the typical myocardial changes found in the late stages of heart disease in Friedreich's ataxia. It is assumed that her death was due to diabetic acidosis and hypopotassemia. The 18-year-old boy (Case 2) who was carefully observed and treated for his cardiac arrhythmia showed at autopsy the typical myocardial changes. It is interesting that under treatment he did not die directly from his cardiac disease, but from a cerebral thrombosis, the etiology of which remains obscure to us.

The presence of rheumatic fever sequelae in Case 2 is excluded, and further the autopsy showed no valvular nor rheumatic myocardial disease, active or healed. The third sibling (Case 3) also succumbed to an acute arrhythmia with shock, and she had glycosuria and hyperglycemia. The fourth (Case 4) and only surviving sibling has electrocardiographic and electroencephalographic abnormalities. She had a diabetic glucose tolerance curve, and she has had two episodes of cardiac arrhythmia precipitated by emotional disturbance.

This represents a striking similarity to the precipitating cause of arrhythmic episodes in her older sister (Case 3). Also quite similar in both of the sisters is an elevation of the white blood cell count, unassociated with fever or evidence of infection. One may speculate that an increase of sympathomimetic amines might be responsible for these two findings: leukocytosis and precipitation of arrhythmia; although we have not done catecholamine studies to date, such studies are contemplated in the surviving sister should similar episodes recur.

The autopsy findings in two of the three cases demonstrated hypertrophy of myocardial fibers, some interstitial fibrosis, sparse mononuclear cell aggregates, but no coronary artery, endocardial or valvular disease. The etiology of the heart disorder in Friedreich's ataxia is not elucidated by our study.

Various mechanisms have been speculated by other investigators. Fatty degeneration of the myocardium was said to be present by Friedreich,[1] Loiseau,[22] and Russel.[23] Others stated that a diffuse chronic interstitial myocarditis was present, quoting Pitt,[2] Pic and Bonnamour,[24] Lannois and Porot,[25] Russel,[23] Schuler,[21] James et al,[18] Boyer et al.[5] These findings are not confirmed by all reviewers.

Fatty degeneration was absent and interstitial myocarditis was minimal in one of our three autopsied cases. It has also been postulated that an associated metabolic defect or disturbance may be present affecting both the myocardium and central nervous system (Boyer et al).[5] This genetically determined defect was first suspected by Russel[23] and emphasized by Boyer et al[5] and Manning.[4]

It has been suggested by Evans,[26] Manning,[4] and Thoren[20] that cardiac involvement should be sought, even without the evidence of the neurologic disturbance. Evidence offered for the latter is the presence of char-

acteristic electrocardiographic changes in close relatives who are free of neurologic symptoms.[20,27] Thoren[20] theorized that two different genes may be defective and that isolated cardiopathy may present the heterozygotes and actual carriers of the disease. Evans suggests that the metabolic defect might affect the myocardium alone, the central nervous system alone, or both together, and therefore, some cases of idiopathic familial cardiomegaly might be related.[26]

Russel,[23] Lannois and Porot[25] and Lambrior[28] postulated a "toxin" to account for the changes in the myocardium and central nervous system—the toxin leading to the degeneration and destruction of individual muscle fibers accounting for the fatty degeneration, interstitial fibrosis, and inflammatory infiltration of the myocardium. Loisseau,[22] Guillain and Mollaret,[15] Phillipe and Oberthur,[29] and Pic and Bonnamour[24] proposed degeneration of vagal nuclei resulting in a sympathetic hypertonia, in turn resulting in myocardial disease. This finding has not been confirmed by other investigators and was rejected notably by Russel.[23]

Coronary artery changes characterized by intimal fibrosis and medial hypertrophy resulting in myocardial ischemia, fibrosis, and hypertrophy has also been advanced as a cause of the cardiac manifestations.[11,18] Coronary artery changes have not been universally described, nor were such changes present in our cases.

The electrocardiographic changes encountered in our three cases represent the entire scale of reported electrocardiographic abnormalities, namely paroxysmal arrhythmias, nonspecific ST-T changes and tracings similar to myocardial infarction. Kyphoscoliosis which is invariably present, however, could explain a change in cardiac position, axis, and ST-T changes.

Three of our cases manifested signs of diabetes mellitus. In our review of the literature, 48 cases have been confirmed, although Thoren, in 1962,[30] indicated an additional 5 cases, the references to which were not available to us. In 1964,[31] Podolsky et al,[31] stated that their 2 cases brought the total of this association of diabetes mellitus and Friedreich's disease to 52 cases, although a table was not included. Therefore, it is evident that approximately 50 of the 333 reported cases of Friedreich's disease, or approximately 15% of the affected persons, may have, or will develop, diabetes mellitus.

Of further interest is the observation that over two-thirds of Podolsky's propositi affected with diabetes mellitus were females. All three female siblings in our family had diabetes mellitus. In all cases reported, as well as in ours, the usual onset of diabetes mellitus is several years later than the onset of the ataxia, in contrast to the heart disease which may precede or follow the onset of the neurologic disturbances. The diabetes mellitus may be responsible for the mode of exitus in some of these cases, as it was in one of ours. Schlesinger[14] suggests the possibility of a hypothalmic lesion as a part of the central nervous system degeneration, contributing to the development of the diabetes mellitus. However, to our knowledge, no such lesion has been demonstrated, nor was it found in our cases. Although it was not found in our studies, it must be stated that this change was not specifically considered in detail at the time the brains were available. However, this intriguing concept deserves meticulous scrutiny in further autopsy studies.

The finding of petechiae preterminally in two of our cases (Cases 2 and 3) for which we have no explanation, has intrigued us. A Rumple–Leeds test was negative in Case 2; none was done in Case 3. It is not felt that medications contributed to these, although the role of quinidine cannot be excluded definitely in Case 2.

Of further interest is the sequence of events that led to death in Case 2; namely, two days after the petechiae were present and quinidine had been discontinued, the propositus died of a thrombosis of the internal carotid artery. The possibility is that preexisting endothelial damage led to thrombosis of the cerebral vessel. The only case in the literature sustaining a vascular lesion was in Pitt's case[8] where he reported "absence of one radial pulse, endarteritis of one vessel and a replacement of one vessel by a fibrous cord."

Treatment for the cardiac manifestations has been conservative and symptomatic: digitalis and diuretics for congestive failure and quinidine and other antiarrhythmic drugs for the cardiac irregularities. Digitalis and quinidine were used in our cases. Steroids were added in the hope of slowing or halting the myocardial process and

thereby ameliorating the conduction defect which might be caused by edema about the conduction system. We have not found any evidence in the literature that steroids have been used previously in this disease, nor did they appear to be beneficial in Cases 2 and 3.

Emotional upset seems to trigger cardiac arrhythmias, as noted in Cases 2, 3, and 4. The prophylactic treatment with rauwolfia serpentina could possibly be beneficial because of catecholamine depletion and is presently being used in the last surviving sibling. In view of some of the findings discussed above, beta receptor blockade should be tried in the future.

The early detection of the diabetic tendency through glucose tolerance tests and the occasional reevaluation of blood sugar levels may also prompt an early treatment or dietary restriction of carbohydrate, the benefit of which would need controlled follow-up.

SUMMARY

A family with Friedreich's ataxia has been reported; the oldest child died of diabetic acidosis, and there is no record of a definite myocardial lesion. The second child died of cerebral thrombosis but had the typical cardiac manifestations as described in Friedreich's ataxia. The third child died a cardiac death and had definite diabetes mellitus. The younger sister is still alive, wheelchairbound, and has occasional cardiac arrhythmia, an abnormal electrocardiogram, and a diabetic glucose tolerance curve.

It is speculated that in Friedreich's ataxia, a genetic defect is present that not only affects the central nervous system but also the heart and the endocrine system. The heart lesions can possibly occur in an isolated condition. All patients with Friedreich's ataxia and also their siblings and relatives should have electrocardiographic and diabetic evaluations. It is felt that the lesion of the heart would best be classified as a "myocardiopathy," since a classical myocarditis is not found.

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* * *

CALIFORNIA HAS THE largest number of veterans of the 50 states, 2,749,000. New York is second with 2,445,000 veterans and Pennsylvania third with 1,684,000 veterans. Other states with more than one million veterans are Illinois, 1.48 million; Ohio, 1.43 million; Texas, 1.28 million; and Michigan, 1.09 million, the Veterans Administration reports.

Methysergide Maleate (Sansert) and the Prevention of Migraine

By J. D. KABLER, M.D.
Madison, Wisconsin

COMMENTS ON TREATMENT

Presented through the cooperation of the Department of Pharmacology, Marquette University, Milwaukee, and the Department of Medicine, University of Wisconsin, Madison

HAROLD F. HARDMAN, M.D., Ph.D., Co-Editor
Marquette University School of Medicine

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University of Wisconsin Medical School

■ FOR THE FEW PERSONS with very frequent migraine, or those who are among the minority (about one-tenth) for whom ergotamine tartrate is ineffective by any route in any reasonable dose, headache prevention is desirable if it can be achieved. At the present time, headache prevention by drug therapy is confined to the use of methysergide, tradenamed Sansert in this country. Sansert is a chemical relative of ergotamine tartrate but possesses quite different pharmacologic properties. It is a relatively feeble vasoconstrictor but a potent serotonin antagonist. Because the role of serotonin in the migraine syndrome is still unclear, it is uncertain that the anti-serotonin action of methysergide is in any way responsible for the ability of this drug to suppress migraine. Whatever may be the mechanism, substantial evidence has accumulated in the past several years demonstrating that methysergide will alleviate or entirely suppress the headaches of two-thirds to four-fifths of persons with migraine.

Unfortunately, however, there are special problems involved in methysergide therapy. Unlike ergotamine tartrate, methysergide has no ability to abort the single attack but rather must be taken several times daily every day as a preventive. The usual minimum initial effective dose is one tablet (2 mg) taken three times a day. Methysergide is relatively expensive and the described minimum dosage will cost about $20.00 a month. For these reasons among others, methysergide has been recommended only gide were apparently done with persons having migraine of the usual full range of interval, duration, and intensity; and I therefore doubt that methysergide has been established to be valuable for the limited for those persons with frequent, severe migraine. Reported evaluations of methysergroup with exceptionally severe migraine for whom this drug is appropriate. In fact, I compared methysergide with a placebo in a controlled evaluation using persons selected beforehand because of the frequency and severity of their migraine attacks. Under the conditions of that study, methysergide was no better than the placebo. This implies, of course, that methysergide may be least effective in those very persons for whom it is supposedly intended and most needed!

In addition to questions of efficacy, there are problems of toxicity. Methysergide causes nausea or vomiting often enough to require special instructions to the patient. The tablet should be taken *during* a meal, and if taken at bedtime it is best to eat again. Another technic to avoid nausea and vomiting is to begin treatment with suboptimum doses—one tablet a day for example—and gradually increase the number of tablets per day to a hopefully effective quantity. Despite such precautions, from 5% to 15% of patients may find the gastrointestinal effects of methysergide intolerable. For the majority, however, the nausea of the first few days of treatment will wane and the drug can be continued in comfort.

There are two serious hazards, however, that limit the use of methysergide. Both of them are rare but they cannot be easily anticipated and may not be reversible if they do occur.

From the Department of Medicine, University of Wisconsin Medical School.

The first of these toxic hazards is a severe sustained peripheral vasospasm culminating in tissue necrosis and gangrene, even in the absence of any antecedent peripheral vascular occlusive disease. It is curious that this ever happens at all considering methysergide's weak vasoconstrictive effect. However, methysergide has been observed to potentiate norepinephrine's vasoconstrictor action and this phenomenon is one postulated explanation for those few instances of serious arteriospasm apparently precipitated by methysergide.

The second special hazard of protracted methysergide treatment is retroperitoneal fibrosis. This rare disorder is characterized by progressive retroperitoneal fibrous tissue proliferation which surrounds and ultimately constricts ureters, blood vessels, and nerves producing hydronephrosis, vascular occlusion and abdominal pain. Retroperitoneal fibrosis had been an exceptionally rare but recognized disorder before methysergide was developed. Nevertheless, there are now about 30 reported instances of this disease associated with extended methysergide treatment. Association does not prove causation and many thousands of persons have taken methysergide without developing retroperitoneal fibrosis. Despite this, the otherwise very rare occurrence of retroperitoneal fibrosis permits a strong inference that its association with methysergide is more than chance.

Even so, if there is an ample indication for using methysergide, no reasonable alternative treatment is applicable, and adequate periodic evaluations can be done, the calculated risk of these rare complications is acceptable. Proper precautions in the opinion of one group of investigators should include treatment interruption for three months every year, frequent urinalysis and renal function tests, a full assessment of peripheral vascular integrity together with intravenous pyelography every three to six months, plus a thorough evaluation of every abdominal pain. The cost and inconvenience inherent in these recommendations must be weighed against any hoped for benefit from methyergide treatment.

Based on the above considerations, I avoid prescribing methysergide unless there is no other option. There is at least one exception to this policy—the migraine variant, "cluster headache" or "histamine cephalgia." For reasons unknown, methysergide better prevents attacks of this variety than other forms of migraine. Furthermore, this uncommon migraine variant tends to appear in four to eight week-long "clusters" separated by intervals of months between the "clusters." Thus, the shorter duration of suppressive treatment needed, the lower doses usually required, and the opportunity for long periods without treatment make Sansert an important treatment for this syndrome.

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Only licensed physicians and registered pharmacists may sell contraceptives and abortifacients or articles appropriate to that use and sold with the intention that they be so used. In no event may such article, drug or preparation be sold to any unmarried person.

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Reference: Section 151.15, Wisconsin Statutes, 1965.

OCCUPATIONAL HEALTH GUIDE

For Medical and Nursing Personnel

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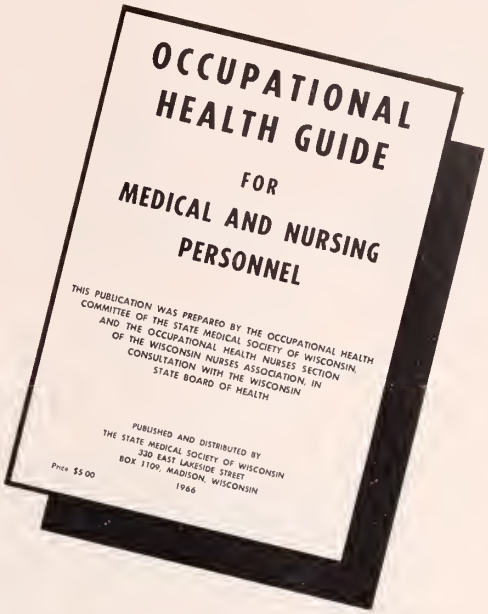

This Guide is concerned with the scope and objectives of occupational health programs and, in particular, with the functions and relationships of physicians and nurses in this health field. It sets forth the shared responsibilities, as well as those of each of the professions. The Occupational Health Committee of the State Medical Society of Wisconsin deems it essential for the development of a sound occupational health program that a physician be appointed to serve as a medical director. His services are necessary in the proper conduct of the employee health program and to provide medical direction for the occupational health nurse. These principles were first stated in 1932 when the State Medical Society of Wisconsin published "Suggestions for the Guidance of the Nurse in Industry." It was the first statement by any medical society in the nation formally acknowledging responsibility for establishment of a well-defined relationship between physicians and professional nurses working in occupational health programs. This is the second revision of the original publication. Each edition has stressed the need for concise, written medical directives from the physician. When the physician serves on a part-time, consultant, or other basis, written medical directives are needed to guide the occupational health nurse in making a provisional diagnosis and determining the next step in the care of ill or injured employees. It is fully recognized that today the preventive aspects of employee health services are and should be receiving increased attention from occupational health physicians and nurses. However, one of the nurse's major functions continues to be the emergency care of injured and ill employees. For this reason, a major portion of this publication has been devoted to the development of medical directives. A practical manual, it covers a wide range of subjects from "Abdominal Injuries" to "Wounds," suggesting steps to be taken, and providing space for specific instructions of the plant physician.

The looseleaf format affords an opportunity to add material which may have particular pertinence to a specific industry and occupational exposure.

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THE PRESIDENT'S PAGE

HAROLD J. KIEF, M.D.

SMS means aggressive leadership

Rustling in the Hustings

■ THERE'S RUSTLING IN THE HUSTINGS that should attract the attention of every physician. It is the early restiveness of the politicians getting ready for November, 1968. The sounds you hear are the germinating seeds of political controversy. The movement you see is the preliminary jockeying for position on the political springboard. You might even get the scent of campaign fever which your olfactory system may regard as pleasant or offensive depending upon your political leanings.

The fact is: that great American political process known as electioneering is once more in the making. Physicians need to recognize the symptoms and prescribe accordingly.

We, in Wisconsin, have a new product specifically developed for this situation. It is called PACE (Professional Association for Civic Education). Its generic name is "Political Action." It costs $25 for a year's supply (the price of annual membership for a professional man), or $40 for the family size (membership for husband and wife). Membership is obtained by sending your application and check to PACE, 144 W. Madison St., Waterloo, Wis. 53594.

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The case for PACE was concisely stated by a Wisconsin Congressman speaking at a recent dinner honoring legislators. He said:

"Through PACE, and as individuals, you can be year-round politicians. Too many professional men don't become politically conscious until November—four or five months after the primaries. By this time it is too late! The candidates are stuck with their commitments."

He might also have added that by this time next year the candidates have fixed their platforms, the billboard and advertising slogans and space have been selected, the budgets decided, the campaign workers recruited. Except to vote, it is too late to make any helpful contribution to the party or candidate of your choice.

Remember, Doctors, you were citizens before you received your medical degree. It is your duty as a citizen to promote legislation that is in the best interests of your patients' health, now that you are a physician. It is your duty to seek out legislators and candidates with educational material provided by PACE to ensure the passage of legislation in the interest of our nation's health.

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PACE is another mechanism where we physicians can demonstrate aggressive leadership. Four thousand doctors under the action banner of PACE can make their voice heard.

Now is the time to heed the rustling in the hustings. Now is the time to join PACE!

H J Kief MD

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EDITORIALS

D. N. GOLDSTEIN, M. D., *Editorial Director*

Defalcations in the Hospital

■ NOT ALL OF THE high cost of hospital care comes from inefficiency, it seems. Employee dishonesty, waste, and indifference account for an increasing portion of the rise in hospital costs.

Norman Jaspan, president of Norman Jaspan Associates, a firm of management engineers in New York, recently told the annual national meeting of hospital accountants at Ohio State University that indifference and dishonesty run rampant in hospital operation despite the best intentions of serious and conscientious administrators.

Mr. Jaspan reported a nationwide hospital survey indicated that an 80% increase in losses due to employee dishonesty occurred in the last five years; that malpractices by supervisors, technicians, and professional personnel account for twice as many dollar losses as rank and file; and that among the most serious and significant losses are those which occur in purchasing, cashiering, pharmacy, and central supply. He also pointed out that recent wage increases have resulted in only marginal productivity gains.

Jaspan told the hospital accountants that the total assets owned by hospitals exceed those of the entire automobile industry, yet the methods of fact-finding and control are relatively primitive. Although there are probably no more dedicated and harder working executives with a more vital degree of responsibility than hospital administrators, Jaspan said, they don't really know what is going on beneath the surface of their operations. And cost increases of over 30% in the last two years, with even larger increases looming in the immediate future, confirm that the existing administrative practices of hospitals are inadequate for the magnitude and complexity of the job.

This is not the first time that hospital administration has been criticized for its unbusiness-like methods. While it can be argued that the hospitals can't be run with the objectivity of businesses—and this might come as a surprise to some patients who have run afoul of the coldblooded business approach of the hospital front-offices—there is no doubt that scientific methods of business management could result in operational savings of money. Mr. Jaspan recommends a well-defined system of accountability and responsibility for hospital personnel.

Hospitals, because of their nature, enjoy a near monopoly in the furnishing of service. The patient can't argue with a hospital, or shop for hospital service any more than he can for gas, water, electricity, or street-car transportation. Yet hospitals, of all public utilities, are without government regulation. And this is as it should be.

For that very reason, hospitals owe it to their patients as well as to all those involved in furnishing health care, to run as efficiently and honestly as possible. They should be self-regulating within a framework of high moral responsibility to the patient.

If the cost of hospital care goes up even partially because of employee dishonesty, hospitals should shake themselves up from top to bottom. Hopefully, modern, efficient methods of business administration will help keep hospital costs from further inflation. —D. N. G.

Federal Style Solution

AS INEVITABLY as death and higher taxes, the Health, Education and Welfare Department has come up with the most ridiculous of all possible suggestions for alleviating the shortage of physicians. If doctors were to work more efficiently, they say, they could treat more patients and naturally there wouldn't be such a dearth of doctors.

This is true. If patients could line up for examination wearing raincoats and army boots like they did (or perhaps still do) in the army for the celebrated short inspection, doctors could really see lots of patients in a very brief time. With the proper cooperation of pregnant women, all babies could be born at convenient times between the hours of nine and five, on schedule, instead of at the erratic, inefficient hours they pick now.

Patients with illness could wait in line, be processed by one set of doctors, be passed on to another set who would examine from the toes to the knees, then to a third set who would look at the anatomy from the knees to the navel, and so on.

Examinations could be given by the numbers, as could procedures such as injections, surgery, bone setting, and the like. Naturally, manuals would have to be prepared so that doctors could understand the most efficient and approved methods, and the glorious possibility of treating more patients per 24-hour period would more than compensate us for the labor of memorizing the standard operating procedure for such things as stripping down the M-1 syringe (with eyes blindfolded) or treating rare tropical diseases.

And woe betide the patient whose lack of cooperation violates the grim efficiency that could be laid upon us!

Unquestionably, doctors could treat more patients—if they were sufficiently regimented. But as long as patients remain human beings and insist on human dignity in their relations with their doctors, HEW's suggestion is as unworkable as a foot-propelled flying machine.

Even assuming the patient load of each doctor were increased by as much as 50%, the problem of shortages would persist because the present geographical distribution of doctors does not provide adequate medical care over large areas of the country.

Almost any doctor can give HEW a better suggestion for making more profitable use of the doctors time: simply eliminate some of the forms that must be completed by doctors who treat patients. With less time spent on red tape, more time could be spent on patients.—D. N. G.

SPECIAL TO THE JOURNAL

KIDNEY TRANSPLANTATION PROGRAM

at the University of Wisconsin Medical Center

FOR APPROXIMATELY eighteen months, the Universty of Wisconsin Medical Center in Madison has been engaged in a clinical program of kidney transplantation. To date, ten patients have received transplants. Nine of these patients have excellent kidney function and are completely rehabilitated and are working full time at their previous occupations, at school, or in their households. The tenth patient has had two attempts at cadaveric transplantation and has rejected both kidneys. He is now being supported by twice weekly hemodialysis. Three additional patients have been accepted into the living donor transplantation program and will be receiving kidney transplantations from sibling or parent donors in the next two months.

The kidney transplant program is a cooperative effort of the Medical, Surgical and Genetics Departments with many other divisions and departments functioning in advisory and consultive capacities. Initially the effort was in cadaver kidney transplants, and five patients were transplanted. Four of these patients have well functioning cadaveric renal transplants. With the development of the mixed leukocyte culture test in the Department of Medical Genetics, an attempt at matching sibling and parent donors was initiated.

The mixed leukocyte culture test is a matching test and is thought to measure the major histocompatibility locus in man. The leukocytes of two people who differ greatly at this locus will be stimulated to great activity when mixed together in a test tube. This activity can be accurately measured by the use of radioactive thymidine and a scintillation counting chamber. Recently different degrees of stimulation have been quantitated, and it is now believed that siblings who are identical at this locus (zero stimulators) can be differentiated from siblings or parents who differ by one allele (moderate stimulation) or two alleles (great stimulation).

The goal of the program is not only to attempt to offer the patient with terminal renal failure some hope for a prolonged life span but also to quantitate and qualitate some of the factors of the genetics of transplantation. The main questions are two: (1) Does a kidney from a donor who is considered a good match by mixed leukocyte culture (zero stimulation) survive and function for significantly longer periods of time than moderate stimulators or great stimulators? (2) With what degree of dissimilarity can transplanting be done and still, by the use of immunosuppressive drugs, have prolonged and excellent graft function? The answer to the second question is extremely important to determine if cadavers can ever be the main source of kidney or other organs for transplantation.

The evaluation of a patient and a potential donor for kidney transplantation is complex, and it is the desire of the transplant group—particularly the Division of Nephrology in the Department of Medicine—to see the patient with progressive chronic renal disease before (if possible) dialysis is needed to maintain life. This allows for careful evaluation of the potential recipient. If transplantation is thought to be necessary and medically feasible, all voluntary, potential donors in the patient's family are tested in mixed leukocyte culture. The most suitable donor or donors, as predicted by the mixed leukocyte culture test, are then critically evaluated for the presence of any unsuspected renal disease as well as for any other health problems which might contraindicate their serving as kidney donors. This study includes a careful evaluation by three examiners, a complete study of renal function, roentgenographic studies including intravenous pyelography and renal arteriography, psychiatric evaluation, and gynecological evaluation if the potential donor is a woman. When it is determined that the potential recipient can no longer sustain life with his own kidney function, dialytic support is initiated in preparation for bilateral nephrectomy and subsequent transplantation. The best matched member of the patient's family acts as the donor.

It is hoped that through this program that a service will be offered to the physicians of the state of Wisconsin and also that a substantial body of knowledge will be added to the field of organ transplantation.

Potential candidates for renal transplantation are seen for initial evaluation in the Medical Renal Clinic or in the Medical Renal Inpatient Service at the University Hospital.

* * *

THE UNIVERSITY OF WISCONSIN has been awarded a $29,400 grant by the U.S. Public Health Service for studies on the early detection and control of cancer. The grant was one of 131, totaling $4,629,334, awarded by the federal agency. The money will be used to increase the average cure rate in cancer by stimulating earlier diagnosis and to disseminate existing knowledge through demonstration, training, and developmental projects.

* * *

THE AMERICAN CANCER SOCIETY will provide free exhibits for medical, dental or nursing meetings, and displays for hospital staff rooms, medical libraries, etc. Call your local ACS office for further information.

REPORTS AND PROCEEDINGS OF 1967 ANNUAL SESSION HOUSE OF DELEGATES

State Medical Society of Wisconsin
MAY 8, 9 and 10, 1967

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Supplement to WISCONSIN MEDICAL JOURNAL
September 1967

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REPORTS PRESENTED TO THE HOUSE OF DELEGATES AT THE ANNUAL SESSION

State Medical Society of Wisconsin May 8–10, 1967

The Annual Session of the House of Delegates of the State Medical Society of Wisconsin was held at the Sheraton–Schroeder Hotel in Milwaukee, May 8–10, 1967.

Presented below are reports submitted to the House. Following these reports are the Proceedings of the House which include the recommendations of the reference committees and the House actions on these reports.

Report No. 1

REPORT OF COMMISSION ON SCIENTIFIC MEDICINE—May 1967

J. K. CURTIS, M.D., Madison, Chairman
W. T. RUSSELL, M.D., Sun Prairie
T. V. GEPPERT, M.D., Madison
OVID MEYER, M.D., Madison
EDGAR S. GORDON, M.D., Madison
ALBERT MARTIN, M.D., Milwaukee
J. A. KILLINS, M.D., Green Bay
R. A. STARR, M.D., Viroqua
B. R. LAWTON, M.D., Marshfield
A. V. PISCIOTTA, M.D., Milwaukee
VICTOR S. FALK, JR., M.D., Edgerton, ex officio
PETER L. EICHMAN, M.D., Madison, ex officio
G. A. KERRIGAN, M.D., Milwaukee, ex officio

Scientific activities of the Society are varied, and many are more intimately associated with special groups within the Society than with the Commission on Scientific Medicine. For example, the details of the Maternal Mortality Study Committee are reported to the House through the Division on Maternal and Child Welfare. Therefore, this report will be of a rather general nature and will seek to avoid overlaps with other reports submitted to the House.

The Annual Meeting

This year's Annual Meeting has been developed cooperatively with major specialty societies and promises to be more coordinated than most programs in the past. Most of the programs have been developed around the general theme "Controversies in Medicine," and it is hoped that the various areas of debate appeal to a wide range of the membership.

In anticipation of the Program in 1968, the Commission is considering support for a "high level" program on some special scientific subject which will immediately precede the usual format of the specialty programs. If successful, this experiment in program construction will be developed in future years and promises to direct public and professional attention to the leadership of our state in matters of scientific medicine. Plans call for international as well as national authorities as speakers and everything will be done to make this a meeting of national stature.

Associated Teaching Programs

Again the State Society, in cooperation with the University of Wisconsin Medical School and the Madison Chapter of the Wisconsin Academy of General Practice, has presented a series of five one-day conferences. The programs in 1966–67 have covered the areas of gastroenterology, obstetrics, pediatrics, surgery, and intensive care units in hospitals. Attendance was substantially higher than former years, partly because of intensified publicity and also the attendance of some members of the Wisconsin Osteopathic Association. It is anticipated that the University will again assist with similar programs in the ensuing year.

During the past year, the Pediatric Department at the University of Wisconsin requested the State Society to help organize a series of local programs which provided case material from local physicians. Two such programs were held in Stevens Point and Sheboygan. The physician participation was not large, but those who attended, as well as the faculty, felt that meetings of this character have value and might be provided in other areas of the state.

During the year, initial steps have been taken through the Division on Maternal and Child Welfare to set up a series of prematurity institutes, and it is hoped these can be developed and presented in 1967–68.

The Division on Nervous and Mental Diseases again presented an excellent scientific program on "The Geriatric Patient" in Eau Claire which was developed cooperatively with the Commission on Scientific Medicine. This annual program has been well received and the Division is to be commended in taking the initiative to provide stimulating instruction of wide appeal to many members of the Society.

Speakers Service

The Speakers Service to County Medical Societies has been continued for the fifth consecutive year. With substantial support of the Wisconsin State Board of Health, the Wisconsin Division of the American Cancer Society, the Wisconsin Heart Association and the Postgraduate Teaching Program of Merck Sharp & Dohme, this service has been provided without material cost to the Society. Through March, 40 speakers have been furnished with 22 counties utilizing the service the past academic year. In addition, the Speakers Service has provided an outright grant of $500.00 to Milwaukee County in support of its annual fall scientific assembly and $106.00 to provide a speaker for the Wisconsin–Upper Peninsula (Michigan) Ophthalmological Society for its September meeting in Menominee, Mich.

Wisconsin Regional Medical Program

With the development of the Wisconsin Regional Medical Program, many educational programs in the areas of cancer, heart and strokes will be provided and it is important that the State Medical Society keep in close touch with this Federal program and give it the proper medical direction needed. At present, a strong Medical Advisory Committee has been formed with members of the State Medical Society constituting most of the membership. In this manner, the work of the State Society and the Regional Medical Program can be properly correlated in a manner most effective as a service to physicians in Wisconsin.

Many changes are taking place in the areas of medical education and postgraduate instruction. While the State Society will continue to provide a strong Annual Meeting and to present special programs as demands arise, it must be recognized that members no longer are solely dependent upon their State Society for postgraduate instruction. The State Society will continue to assist other groups in their instructional programs directed to physicians and will fill in where needs exist. The Commission on Scientific Medicine is interested in fostering scientific programs through all branches of the State Society and is prepared to assist with program planning and consultation in all areas of postgraduate medical education.

Report No. 2

■ REPORT OF COMMITTEE ON OCCUPATIONAL HEALTH OF COMMISSION ON PUBLIC RELATIONS AND COMMUNICATIONS—May 1967

JAMES M. WILKIE, M.D., Madison, Chairman
DONALD M. RUCH, M.D., Milwaukee
J. V. FLANNERY, M.D., Wausau
R. S. WRIGHT, M.D., Racine
OTTO T. MALLERY, M.D., Wausau
CARL ZENZ, M.D., West Allis
LOUIS OLSMAN, M.D., Kenosha
ALLEN G. BRAILEY, M.D., La Crosse
WILLIAM W. FORD, M.D., Green Bay

Since last reporting to the House, the Committee on Occupational Health has been active in a variety of areas and is pleased to make the following report for the past year:

Occupational Health Guide

The publication of this important Guide has been completed and is being widely distributed, not only in Wisconsin but in other states and in foreign countries. This joint effort of the Occupational Health Committee and the Occupational Health Nurses Section of the Wisconsin State Nurses Association has been favorably reviewed in national industrial health and nursing bulletins and has directed attention to the outstanding work we in Wisconsin are doing in this area of medical and nursing practice. Those physicians not yet familiar with this publication are urged to purchase copies if they are in any way associated with plant health programs.

Industrial Health Clinics

In the last report of this committee, attention was directed to the renewal of Industrial Health Clinics with the initial conference held at the Allis Chalmers Plant in Milwaukee. This program was well received and provided the avenue for good public relations with management, the nursing profession and other groups interested in the health of industrial workers. Plans are being developed for a second clinic in Wausau during the fall of 1967 and a special conference on "Health Problems Associated with the Manufacture and Use of Insecticides and Pesticides" in Racine in the spring of 1968. This latter conference will be developed cooperatively with the Rural Health Committee of the State Society, the College of Agriculture at the University of Wisconsin and other farm groups.

The House in October approved of the further development of Industrial Health Clinics and the Committee will attempt to organize them in a manner which will be most helpful for physicians and others concerned with the health of Wisconsin workers in industry.

Health of Migrant Workers

In October the House asked that the Committee study the health of migrant workers and report on this subject. Initial steps have been taken by way of consulting with the Wisconsin State Board of Health, the Wisconsin Canners Association and the Wisconsin Committee on Migrant Labor. It is apparent to the Committee that much constructive work in areas of health has been undertaken without full recognition on the part of the public. Scores of physicians and nurses as well as lay people associated with churches or voluntary health organizations have set up effective health and environmental programs in areas where most migrant work is conducted. In large measure, Wisconsin has provided better health facilities and health services than most states through which these thousands of Texas–Mexicans travel and work during the course of the year. In many instances, these workers have remained in Wisconsin and have been absorbed into the community.

It is the consensus of the Committee on Occupational Health that major attention should be directed to more publicity as to what physicians, nurses and other groups in Wisconsin *have done*, and to direct special attention to smaller communities which have not yet developed facilities to equal those in the major work areas of Dodge, Door, Marquette and Waushara Counties.

The Committee on Occupational Health will be pleased to assume continued responsibility in this area and will make further reports to the House as new programs are developed and existing programs improved. The groundwork for cooperative effort has been established and the continued cooperation and concern of physicians groups in the various counties where migrant workers are employed will be of assistance to the Committee on Occupational Health.

Reporting Forms

More than two decades ago, the State Medical Society, with representatives of the insurance industry and the Workmen's Compensation Division of the Wisconsin Industrial Commission developed reporting forms for all compensation cases and for pre-employment examinations. The Committee has undertaken a project of reviewing with appropriate parties the forms now being used to see if reporting can be made more effective and with more ease for the reporting M.D. If the Committee is able to accomplish anything in this area, it will be reported to the House in 1968.

The Committee is active, members are interested in the work and we have made many valuable contacts with other groups this past year. We hope the House approves of what has been done and the Committee will welcome any suggestions as to new projects which it is felt should be undertaken.

Report No. 3

■ REPORT OF COMMISSION ON HOSPITAL RELATIONS AND MEDICAL EDUCATION—May 1967

G. B. MURPHY, JR., M.D., La Crosse, Chairman
DALE V. MOEN, M.D., Shell Lake
G. W. HILLIARD, M.D., Milwaukee
L. W. SCHRANK, M.D., Waupun
A. J. RICHTSMEIER, M.D., Madison
R. S. GALGANO, M.D., Delavan
P. C. DIETZ, M.D., La Crosse
S. L. HENKE, M.D., Eau Claire
DONALD E. KOEPKE, M.D., Milwaukee
PETER L. EICHMAN, M.D., Madison, ex officio
G. A. KERRIGAN, M.D., Milwaukee, ex officio

The Commission has considered at length the general subject of women in health, specifically nurses and nursing. During its deliberations on this important subject, it has devoted considerable time and attention to these matters meeting with representatives of the Wisconsin Nurses' Association, the Department of Nurses and the Wisconsin Hospital Association.

In its deliberations, attention was given to a Position Paper of 1965, adopted by the American Nurses' Association. Among the salient points made were:

> "Education for those who work in nursing should take place in institutions of learning within the general system of education.

"The education for all those who are licensed to practice nursing should take place in institutions of higher education.

"Minimum preparation for beginning professional nursing practice at the present time should be baccalaureate degree education in nursing.

"Minimum preparation for beginning technical nursing practice at the present time should be associate degree education in nursing.

"Education for assistants in the Health Service occupations should be short, intensive pre-service programs in vocational education institutions, rather than on-the-job training programs."

The Commission believes this position is too strong to be adopted and heartily recommends the continuation of current existing programs in nurse preparation, particularly those at the hospital diploma degree level.

The Wisconsin State Board of Nursing, in January 1966, adopted the following statement:

"The Wisconsin State Board of Nursing recognizes that the American Nurses Association's first position on education for nursing will have implication for nursing education, nursing practice, nursing service and the training of auxiliary workers in Wisconsin. It also recognizes that economic pressures on hospitals and other developments in society are increasing the movement of nursing education programs into the colleges and universities, the loci of education for all other professions.

"While change in education for nursing is inevitable, the Wisconsin State Board of Nursing recognizes that orderly planning for change to insure an uninterrupted flow of nurses into the community is essential. To this end it (1) supports all of its present programs in nursing, (2) believes that a desirable balance of nursing personnel with various kinds of preparation must be maintained and (3) opposes the termination of any program until such time as the community has established a new program in nursing which will provide for an uninterrupted flow of nurses."

The Commission wishes to further describe to the House of Delegates the action taken by the Board of Directors of the Wisconsin Nurses' Association, relative to the ANA Position Paper. At its March 31–April 1, 1966, meeting, the Wisconsin Nurses' Association Board of Directors voted to:

"Endorse the ANA Position Paper on education for nursing and support the Wisconsin State Board of Nursing Position on nursing education, recognizing that while change of nursing education is inevitable, it is also desirable."

The WNA Board of Directors also authorized appointment of an Ad Hoc Joint Committee to study the future nursing education in Wisconsin. The purposes of this Committee are to study the ANA Position Paper on nursing education in light of the future of nursing education in Wisconsin and to investigate ways and means of implementing an orderly transfer of nursing education programs.

The Commission would like to call to the attention of the House of Delegates the closing of one hospital diploma program in professional nursing in July of this year—St. Mary's Hospital School of Nursing in Wausau.

Other hospital diploma programs in professional nursing are being phased out, but are being replaced by Collegiate Programs in Nursing:

St. Agnes Hospital School of Nursing, Fond du Lac (1966)
Marian College of Fond du Lac (same order of nuns)

Luther Hospital School of Nursing, Eau Claire (1967)
University of Wisconsin—Eau Claire

St. Francis Hospital School of Nursing, La Crosse (1971)
Vitebro College, La Crosse (same order of nuns)

St. Mary's Hospital School of Nursing, Milwaukee (1969)
University of Wisconsin—Milwaukee

New programs for preparing Practical Nurses have been started in Waukesha, La Crosse, and one has been authorized to open in Sheboygan.

The Commission would also like to urge the House to go on record encouraging nurses presently not active in the profession to take refresher courses available at various institutions and to return to the profession of nursing on some type of basis. The Commission further believes that strong differentials in compensation between evening and night duty be established and that this will encourage more general distribution of nursing.

The Commission further believes that a very close look at the present utilization of all categories of nurses be made in each work situation so that the professional nurse is not being utilized to perform duties which are not within her structure and that she is making the best use of her professional preparation.

The Commission would like to call attention to the recommendation that liaison committees between state nurses' associations and state medical societies be established and be active. This suggestion is endorsed both by the American Medical Association's Committee on Nursing and the American Nurses' Association.

The Commission calls attention to a conference on nursing which will be sponsored by the American Medical Association and held at its headquarters in Chicago on October 6, 1967 and urges appropriate society participation in this conference.

Among other items of consideration of the Commission is the report of the Citizens' Commission on Graduate Medical Education commissioned by the American Medical Association, *The Graduate Education of Physicians*, or commonly known as "The Millis Report."

While the Commission has taken no formal action on the recommendations contained therein, it believes that medical education is undergoing a change and must do so to keep pace with rapidly advancing scientific and technical knowledge.

The Commission further wishes to call attention of the House to a Conference on Emergency Medical Care being sponsored by the American Medical Association to be held in Chicago on April 6–7, 1967. It hopes to have a supplementary report outlining the highlights of this conference.

Finally, the Commission strongly urges the Council to designate a body within the structure of the State Medical Society to act as a liaison committee with nurses.* This body would meet periodically with members of the nursing profession to serve as a means of continuing communication between physicians and nurses, to create a deeper understanding of mutual interests and problems and to undertake all projects with nursing on a colleague to colleague basis.

It was suggested in the composition of this body, attention be given to appointment of physicians to it who have direct association with ongoing nursing education programs.

* The Council so designated this Commission on March 11, 1967.

Report No. 4

REPORT OF COMMITTEE ON GRIEVANCES—May 1967

E. W. MASON, M.D., Milwaukee, Chairman
J. D. LEAHY, M.D., Park Falls, Vice-chairman
C. E. WALL, M.D., Manitowoc
D. W. DAILEY, Elcho
O. G. MOLAND, M.D., Augusta
E. D. SORENSON, M.D., Elkhorn
R. W. MASON, M.D., Marshfield
M. F. HUTH, M.D., Baraboo
D. R. GRIFFITH, M.D., Eau Claire

The Committee on Grievances has held two meetings since the Interim Session of the House of Delegates of October 1966.

In its deliberations, the Committee has reviewed 47 cases presented to it, and has made disposition of the majority, holding only a few in abeyance pending further information or developments.

At its November 9, 1966, meeting the Committee reviewed the current Bylaw which describes its function and purposes *(Bylaws, Chapter VII, Section 5)*:

"The Committee on Grievances shall investigate all reported claims against members for compensation for injuries said to have resulted from malpractice. It shall determine as nearly as may be practicable the circumstances leading up to the making of the claim itself and the grounds on which the claim is based. The committee shall recommend to the Society from time to time such measures as it deems practicable for the limitation or removal of the causes of such claims. It may, at the request of any member against whom a claim has been made, place at his disposal such evidence as becomes available to the committee. If the committee believes a claim unjust, it shall, at the request of the member against whom the claim has been made, cooperate, so far as it can lawfully do so, with him and his counsel in defense against it. If the committee believes that the claim that it has investigated is a just claim, the committee may, at the request of the member against whom the claim was made, cooperate with him and his counsel, so far as it lawfully can do so, in effecting an equitable settlement. The committee shall submit a report of its proceedings at each annual meeting of the Society, covering the preceding year, in which report shall be included all recommendations made by the committee during the year looking toward the removal of the causes of claims based on alleged malpractice. The committee shall possess similar responsibilities where request is made to investigate complaints bearing upon a member's alleged violation of any provision of the Medical Practice Act.

"The committee shall consist of nine members and the terms of one-third of its members shall expire each year, with each member appointed for a term of three years."

Upon consideration and study of the present Bylaw and with advice of Legal Counsel the Committee unanimously recommends this section be updated and modified to correctly state the current practical function and purposes of the Committee:

"The Committee on Grievances is empowered to receive complaints concerning individual physicians or groups of physicians, and initiate investigations under standing rules which it may establish. It may review decisions of local grievance or arbitration committees on appeal therefrom, but nothing in this section shall be construed as inconsistent with the provisions of Chapter VI relating to responsibilities of the Council.

"It shall be the purpose of the committee to endeavor to effect an equitable adjustment or understanding, and to resolve such differences between physicians, or between physician and patient or other complainant.

"The efforts of the committee may be extended into areas of interprofessional conduct, the development of appropriate codes of interprofessional relations, and its initial responsibility shall be to the Council of the State Medical Society. It shall consist of nine members appointed for terms of three years, one-third of such terms to expire annually.

"All letters, reports and records submitted or obtained by this committee are for the confidential use of this committee, and no letters, reports and records shall be released for any purpose, or be subjected to subpoena in any trial, civil or criminal."

Report No. 5

REPORT OF DIVISION ON CHEST DISEASES OF COMMISSION ON STATE DEPARTMENTS —May 1967

H. A. ANDERSON, M.D., Stevens Point, Chairman
JOHN H. HUSTON, M.D., Milwaukee
LOUIS G. NEZWORSKI, M.D., Eau Claire
JOHN RANKIN, M.D., Madison
DOUGLAS A. GUTHEIL, M.D., De Pere
A. H. PEMBERTON, M.D., Milwaukee
JOHN H. WISHART, M.D., Eau Claire
B. R. LAWTON, M.D., Marshfield
WILLIAM J. LITTLE, M.D., Racine
RICHARD H. WASSERBURGER, M.D., Madison

In spite of extensive professional and lay educational programs, tuberculosis remains a basic health problem in Wisconsin. With the advent of effective drug therapy, bed occupancy has materially decreased and the future use of tuberculosis facilities is a subject of concern and debate. In spite of lessened bed care, the number of cases of tuberculosis has not materially decreased. Ambulatory treatment has frequently broken down by patients' neglect to follow the instructions of their physicians.

At present, the State Board of Health and the Wisconsin Anti-Tuberculosis Association have undertaken a broad program for total eradication of the disease and all physicians are urged to give this important public health effort full cooperation. The entire profession has received, or will receive "Recommendations on the Use of Tuberculin Tests and Chemoprophylaxis," and it is hoped that individual physicians as well as groups will take an active role in the implementation of this vital program.

The mobile units of the State Board of Health have conducted programs which have been reported periodically to the House through this Division. The declining case findings in the area of tuberculosis alone may cut off support funds which will no longer provide this service to counties which have requested it in the past. The multiphasic services of the units have been well received in most areas and have revealed important unknown cases of heart disease, cancer and diabetes. Current policies in respect to referrals of suspected cases of heart disease have been studied and modifications have been made so that treatment for hypertension will be recommended only in cases where the findings clearly indicate need for treatment. These revised procedures have been

worked out with the Wisconsin Heart Association and should be helpful for physicians throughout the state.

The Division would be happy to report significant progress in the control of tuberculosis in the state, but such a situation does not exist and major improvements will not be made until each physician recognizes his individual responsibility in following the "Recommendations on the Use of Tuberculin Tests and Chemoprophylaxis" which has been prepared by the State Board of Health and W.A.T.A. The Division urges that attention to this important program be made a matter of concern to all county medical societies and to individual practitioners.

Report No. 6

REPORT OF DIVISION ON HANDICAPPED CHILDREN OF COMMISSION ON STATE DEPARTMENTS—May 1967

JOHN J. SUITS, M.D., Marshfield, Chairman
BETTY BAMFORTH, M.D., Madison
MAXINE BENNETT, M.D., Madison
FRANK BERNARD, M.D., Madison
RICHARD E. JENSEN, M.D., Green Bay
JAMES E. MILLER, M.D., Madison
ARTHUR A. SIEBENS, M.D., Madison
ROBIN ALLIN, M.D., Madison
MATTHEW D. DAVIS, M.D., Madison
RAY R. RUECKERT, M.D., Portage
LLOYD P. WILLIAMS, M.D., Appleton

As physicians who have served in the House previously are aware, the Division on Handicapped Children is primarily used as an advisory committee by the Medical Director of the Bureau for Handicapped Children of the Wisconsin State Department of Public Instruction. Several decades ago when the Bureau was first formed and supported by Federal funds, the State Medical Society assumed an important role in setting up policies and procedures which made the programs most effective and acceptable to the practicing physician. Initially, the emphasis was on orthopedic clinics, which were widely used throughout the state before specialists in this field were established in communities outside of Madison and Milwaukee.

Currently the orthopedic program is less active than it was some years ago, but it still fills a need in certain areas of the state and is utilized by physicians upon request of the county medical society. While the program is not extensive, the Medical Director reports 487 new cases referred for study this past year and in 1965–66 out of 5,057 cases served by the Bureau 2,163 were in the area of orthopedic abnormality. The next largest program of the Bureau is in hearing, with 1,677 children served. Smaller numbers are in specialized programs such as cerebral palsy, plastic surgery, vision, cystic fibrosis, meningomyelocele, and mongolism.

It is gratifying to report to the House that the Medical Director of the Bureau for Handicapped Children, Horace K. Tenney, III, M.D., is anxious to utilize the Division as an advisory body and consults with the Division as problems arise.

A new program which will be of interest to members is the mobile otologic unit which will be used during the regular school year for school children and during the summer months for pre-school children. This service may be of great assistance to physicians in areas where children of medically-indigent families are without otologic service in their community or area of the state. As in all programs, this will be made available to counties which desire its use.

The Bureau is aware of the fact that Title XIX may have great impact on its services and may ultimately lead to the suspension of services. The Division is aware of the fact that cessation of services would present a problem in certain areas of the state and it is hoped that the Bureau, under medical direction, and with continued counsel from the State Medical Society, can be continued.

The Division on Handicapped Children is pleased to report full cooperation of the Medical Director, Doctor Tenney, and as new programs are developed or services curtailed, this will be reported to the House in subsequent years.

Report No. 7

REPORT OF DIVISION ON MATERNAL AND CHILD WELFARE OF COMMISSION ON STATE DEPARTMENTS—May 1967

JOHN R. EVRARD, M.D., Milwaukee, Chairman
RICHARD C. BROWN, M.D., Eau Claire
N. M. HILRICH, M.D., Milwaukee
WILLIAM R. KREUL, M.D., Racine
T. A. LEONARD, M.D., Middleton
B. P. WALDKIRCH, M.D., De Pere
E. A. BIRGE, M.D., Milwaukee
STANLEY N. GRAVEN, M.D., Madison
STEWART L. GRIGGS, M.D., Green Bay
K. J. WINTERS, M.D., Wauwatosa
F. G. JOHNSON, M.D., Superior
MERLIN J. OLSON, M.D., Monroe
KENNETH F. PELANT, M.D., Grafton
GEORGE H. STEVENS, M.D., Wausau

At frequent intervals this Division has made reports to the House, and so this report is designed primarily to mention, briefly, existing programs and to outline several areas which are of special concern to the Division.

The Division continues to direct the Maternal Mortality Survey which has been in operation since 1952. While deaths have steadily declined since the start of the Survey, there are still instances of maternal demise which suggest the need for more education directed to physicians and hospital personnel. Most of the problems come within the general area of blood loss, toxemia, inadequate control of heart conditions, diabetes and other medical complications. In many instances, the basic blame rests with the patient (particularly the multigravic) who neglects to seek medical supervision during most months of her pregnancy. In other instances, the medical crisis is of such a character that even with the best of care, the life of the patient cannot be spared. However, there still remain situations which suggest the need for more information on obstetrical emergencies and it is hoped that during the ensuing year, the Maternal Mortality Institutes can be renewed in cooperation with the State Board of Health.

The Division is concerned with the lack of facilities in some smaller hospitals to meet obstetrical emergencies and it has initiated a study with the Wisconsin State Board of Health and the Wisconsin Hospital Association to see if this situation can be corrected, either by upgrading facilities where no other hospitals exist in the community or to close obstetrical services in small hospitals in urbanized areas where more adequate obstetrical facilities are available. As this study is completed, its results and the recommendations of the Division will be transmitted to the House.

The Division has initiated a special perinatal pilot study in Milwaukee to ascertain what areas should be studied intensively to provide greater infant salvage. It is hoped that this preliminary study will provide experience so that more definitive studies

can be carried out in other areas of the state. The results and recommendations of this local pilot study will be reported to the House at a later date.

Prematurity continues to be a matter of concern to the Division. In cooperation with the University of Wisconsin and the State Board of Health, the Division will undertake a series of teaching programs in this area during the 1967–68 year. Physicians and nurses will be encouraged to attend. Also, hospital facilities for the care of premature infants will be studied intensively so that local facilities can be more effectively employed. Possibly special referral centers will also be developed as an outgrowth of this study.

The Division has previously reported to the House the creation of a special obstetrical nurse refresher course of study conducted cooperatively with Marquette University. This continues to be actively utilized and now special consideration is being given to an expansion of the program to provide special courses for practical nurses to further assist hospitals which are unable to secure full obstetrical coverage by registered nurses.

In previous reports, mention has been made of the new legislation on "The Abused Child." The Division has been represented in the formulation of the legislation and now revisions have been introduced which will broaden the base of reporting and also provide immunity from civil as well as criminal prosecution. It is hoped that these refinements of the law will encourage reporting and help to meet the problems which are known to exist. All physicians are urged to give full cooperation in the implementation of this legislation.

Some communities in Wisconsin have sought approval of the State Board of Health to utilize selected obstetrical beds for other use, and if standards of isolation can be met, these modifications have been approved. It is urged that all medical staffs of hospitals become conversant with required standards before any modification in the use of obstetrical beds is undertaken.

As Chairman of the Division, it is my pleasure to report continued interest and participation of Division members and the finest of cooperation with the State Board of Health and the Division of Children and Youth of the Department of Public Welfare in matters of concern to the Division.

Report No. 8

■ REPORT OF DIVISION ON REHABILITATION OF COMMISSION ON STATE DEPARTMENTS—May 1967

PAUL A. DUDENHOEFER, M.D., Elm Grove, Chairman
C. E. KOEPP, M.D., Marinette
JAMES F. McDERMOTT, M.D., Wauwatosa
CHARLES H. FLINT, M.D., Minocqua
R. L. GILBERT, M.D., La Crosse
WILLIAM P. CROWLEY, JR., M.D., Madison
LOUIS KAGEN, M.D., Milwaukee

Since last reporting to the House of Delegates the Division on Rehabilitation has been interested in the several matters listed:

1. Request from psychologists to the Vocational Rehabilitation Division of the State Board of Vocational, Technical and Adult Education that they be permitted to be reimbursed for their services which include treatment without physician supervision of the patient.

The Division was unanimous in its recommendation that there be no change in the present policy which is to provide reimbursement for psychological services only when under the supervision of and such services are billed for by a physician. This policy is consistent with that of WPS Health Insurance Programs which provide benefits for covered services to physicians under medical-surgical coverage.

2. The Division urged the State Board of Health to cooperate with and accept the services of the Wisconsin Division of the Mid-America Society of Physical Medicine and Rehabilitation. One of its functions is to assist in certifying those Extended Care Facilities who offer physical therapy services under the Conditions for Participation for Extended Care Facilities in the Medicare (Title 18) program.

3. A report was received of an AMA Conference on Rehabilitation which outlined many of the Federal and non-governmental aids and services available for rehabilitation.

4. It is recommended consideration be given to presenting a conference for representatives to county medical societies for the purpose of presenting information of available funds for and on-going programs in the fields of physical, speech, occupational and hearing therapy. *Fiscal Note:* It is estimated aside from staff time, out-of-pocket expenses would be $500.00 for a one-day program.

Report No. 9

■ REPORT OF DIVISION ON SAFE TRANSPORTATION OF COMMISSION ON STATE DEPARTMENTS—May 1967

JAMES L. WEYGANDT, M.D., Sheboygan Falls, Chairman
E. E. ECKSTAM, M.D., Monroe
RALPH F. HUDSON, M.D., Eau Claire
FREDERICK BUNKFELDT, JR., M.D., Milwaukee
WALTER F. SMEJKAL, M.D., Manitowoc
RICHARD C. WIXSON, M.D., Madison
ALLEN W. WITTCHOW, M.D., Wisconsin Rapids

Since last reporting to the House of Delegates the Division on Safe Transportation of the Commission on State Departments has been active in many areas which have been gaining increasing public attention. Never before has highway safety received the immense consideration that it has during the past few months. Safe transportation has become such an important issue that the Governor of Wisconsin addressed a joint session of the Legislature on this subject specifically aside from his regular State of State Address.

Reflecting this increased activity in the public forum, the Division has chosen to increase its activity and the basis of many of its deliberations have been policies previously adopted by the House of Delegates. For example, the Society in an effort to develop a long range traffic safety program has previously taken the following positions:

1. In person driver license renewal measures, incorporating a screening procedure to provide for further evaluation of those with gross visual or physical defects;
2. Mandatory driver education courses in all Wisconsin high schools;
3. The requirement of the successful completion of a driver education course prior to licensure for all those under 18 years of age;
4. A special license (with special training and qualifications) for the operation of any two- or three-wheeled motor vehicle;
5. The required wearing of an approved safety helmet by every driver and passenger on a two- or three-wheeled motor vehicle;
6. The adoption of minimum standards for ambulance operation;
7. A broadening of the functions of the Epilepsy Review Board to that of a medical advisory committee, to consider all areas of medical limitation for driver licensing;

8. Adoption of an implied consent law to aid in control and deterrence of the drinking-driving problem;
9. The requirement that all automobiles sold in Wisconsin meet minimum standards for passenger safety devices as established by the Federal Administrator of General Services; and
10. The expansion of first aid instruction for all drivers, particularly those on an emergency service, such as police and ambulance personnel.

The Division has also considered the subject of driver licensing in connection with mental health and feels that this is an extremely important area. A member of the Division on Nervous and Mental Diseases has been added to the Division on Safe Transportation as a consultant and the subject of driver's license renewals will be under consideration for implementation of a previous recommendation which states:

"The present driver's license renewal question pertaining to legally adjudged insane is useless, as two years may elapse before the question is raised following hospital discharge. Corrective legislation has been formulated to require each hospital superintendent to report to the Motor Vehicle Department the name of any committed patient who has left the institution and who is, in his opinion, possibly unsafe to drive. Burden of final decision is left with the Motor Vehicle Department."

During the past few months the new federal safety standards and regulations have been released and these require operator license renewals be made on an "in person" basis. States failing to comply will lose a percentage of their share of the federal highway funds. Since the Society is already on record as supporting "in person" renewals it is recommended that support be given to legislation which will guarantee that "walk in" renewals become a reality.

The Division has also considered the matter of physician liability in administration of chemical tests for intoxication and has requested further legal analysis from the Society's counsel on this subject. This action was stimulated by an Attorney General's Special Memorandum advising that police may "order" a physician to draw blood over the objection of an individual under arrest, and, further, that the physician may be charged with "failure to aid a police officer in the performance of his duties" should he not comply. It is recommended that when a finalized opinion is obtained, it be published in the *Wisconsin Medical Journal* for the information of all members.

Emergency management of the injured has been reviewed and it has been recommended that the Society consider the possibility of reprinting the "Guide for Transporting the Ill and the Injured" which was prepared by the Division (see attached). It has also been recommended to the Council that the statements and principles embodied in this guide be made the subject of legislation which would establish minimum standards throughout the state. In addition the Division has expressed interest in cooperating with the Governor in evaluating emergency personnel resources in the state and will be considering emergency room management of the patient with other Society committees working in the same interest area. Training courses for ambulance personnel are also being considered at the present time.

NOTE: This has been approved by the House of Delegates.

At its last meeting the Division discussed the proposal for a Traffic Safety Research Center at the University of Wisconsin–Madison and recommended that the Society endorse the creation of such a facility which could be of great value in the study of accident causation and driver performance.

Medical examination of school bus drivers has been considered and it is recommended that the Interstate Commerce Commission standards (or their equivalent) be required as at least the minimum standards in Wisconsin and that this position be communicated to school boards and to Wisconsin Legislators.

The Division, in the area of scientific and public education, has cooperated in designing a program for the 1967 Wisconsin Work Week of Health. This day long program will deal with the medical aspects of traffic safety and will be held on Monday, October 16.

Also, the January 1967 issue of the *Wisconsin Medical Journal* had an article dealing with medical examination of driver impairment. This article was prepared by the Division and approved for publication by the Council.

The Division has discussed safe transportation involving areas other than highway safety. For example, the operation of boats has been considered. The Council and the Commission on State Departments have been asked to determine if this Division should consider these items in addition to the area of safe transportation on the highway or if it prefers that this be assigned to another Division in view of the amount of time needed to implement the Society's program of highway safety.

To aid in consideration of the many objectives of the Society, the Division has decided to request representation from the two medical schools in the state and a representative from the Driver Education Division of the University of Wisconsin.

The membership of the Society, and in particular the Delegates to the House, are reminded of a program of notifying the Motor Vehicle Department of inconsistent or dangerous highway warnings or signs. When inconsistencies are noted they should be reported to:

Signing and Marking Division
State Highway Commission
State Office Building
Madison, Wisconsin

Report No. 10

REPORT OF DIVISION ON SCHOOL HEALTH OF COMMISSION ON STATE DEPARTMENTS —May 1967

JAMES C. H. RUSSELL, M.D., Fort Atkinson, Chairman
F. W. REICHARDT, M.D., Stevens Point
ALLAN J. RYAN, M.D., Madison
HORACE K. TENNEY, III, M.D., Madison
WILLIAM T. BRODHEAD, M.D., Madison
FRANCES A. CLINE, M.D., Rhinelander
R. F. POSER, M.D., Columbus

The Division on School Health since last reporting to the House of Delegates has reviewed the health examination reporting form previously endorsed by the Society. At the present time, a proposed revision of the form, to provide for an explanation on the need for special physical education courses, is being considered. The proposed changes would allow the physician to recommend restricted or special physical education courses. At the present time, the form only provides for a recommendation that the student should be excused from physical education for medical reasons.

A revised form or an adaptive physical education form supplementary to the form now being suggested by the Society will be ready for use by physicians and schools during the 1967–68 academic year.

The Division has also discussed the "Guide for School Health Examination" prepared and distributed by the State Board of Health and the State Medical Society. During the next few months, the Division will be working with consultants from the State Board of Health on revising the contents of this publication. Types of publication formats and methods of distribution will also be considered in cooperation with the State Board of Health. Recommendations will be forwarded to the Commission on State Departments and the Council for their review before final action is taken.

All college and university presidents in the state have been contacted regarding health education courses offered in their institutions, and means by which the State Medical Society can be helpful in the conduct of such courses. It was determined that the need for more general information on health education resources is the greatest need at the present time and the Division will continue to supply such information when it is available. The American Medical Association has also been requested by the Division to supply copies of "AMA-Report on Discovering Health Problems in Physical Activity" for distribution to physical education teachers, instructors in health education and students in health education courses.

Another project presently being undertaken is a study to determine how and when physical examinations for school employees and students are conducted. A report with recommendations will be made when this survey and study have been completed.

In addition, the Division has determined that it should continue to survey physical education injuries for at least one more year. This study was originated to find out if specific schools have a greater percentage of injuries and the basic cause for injuries that occur in connection with physical education activities.

Representatives of the Wisconsin Interscholastic Athletic Association meet regularly with the Division and at the last meeting, the rule on hernias was reviewed. The Division concurred with the position that final decision in cases of injury rests with the physician after he has considered the "Guide for Disqualification of Athletes." This guide was prepared by the Society and is attached for the information of the House of Delegates.

Since last reporting to the Delegates, the Division has also cooperated with the Charitable, Educational and Scientific Foundation in planning and producing the Second Wilson Cunningham Memorial Lecture. This program which was held in connection with the celebration of the 125th Anniversary of the State Medical Society featured Jackie Robinson who spoke on physical fitness, a topic which was both timely and germane to the goals of the Division on School Health.

SUPPORT YOUR FOUNDATION

It is your opportunity to give financial assistance to the charitable, educational and scientific aspects of medicine as they relate to the health and well-being of the people of Wisconsin. All contributions to the Foundation are deductible for income tax purposes. Checks may be made out to: CES Foundation, and sent to CES Foundation, State Medical Society of Wisconsin, Box 1109, Madison, Wis. 53701.

Report No. 11

■ REPORT OF DIVISION ON VISUAL AND HEARING DEFECTS OF COMMISSION ON STATE DEPARTMENTS—May 1967

MEYER S. FOX, M.D., Milwaukee, Chairman
MAXINE BENNETT, M.D., Madison
RICHARD H. BRODHEAD, M.D., Wausau
DONALD A. PETERSON, M.D., Madison
E. B. LARKIN, M.D., Eau Claire
GEORGE NADEAU, M.D., Green Bay
C. G. REZNICHEK, M.D., Madison
JAMES V. BOLGER, JR., M.D., Waukesha
RICHARD J. FOGLE, M.D., Racine
JOHN B. HITZ, M.D., Milwaukee

The Division, since last reporting to the House of Delegates, has again considered the organization of visual screening programs for schools. At a recent meeting, it was decided that a revision of the form and guidelines for screening programs now being distributed by the Society should be undertaken. This proposed revision will be done in cooperation with the State Board of Health and the recommendations of the Division for reprinting the form will be sent to the Council and the Commission on State Departments for their review before any final determination is made.

The Division has also considered plans for implementing a series of instruction courses for audiometric technicians as previously approved by the House of Delegates. The current planning envisions a two-day program on audiometric testing in industry and in schools. A registration fee will be charged to defer costs. In addition to this program, the Division is again considering future sponsorship of a program limited to hearing conservation in industry.

Audiometric measurements have been reviewed and the results of this review include the preparation of an article on new audiometric levels for publication in the *Wisconsin Medical Journal.* (This article appeared in the March 1967 issue at page 142.)

The Division is also continuing to investigate the results of its recommendation to the Industrial Commission that a comparative study be made on cases decided on previous Industrial Commission regulations for visual disability and those cases decided on the procedures advocated by the American Medical Association. The results of this study will be analyzed and will be the basis for future recommendations to the Society on the subject of standards used for determining visual disability.

The Division reviewed the proposed plans of the State Board of Health which would provide for a vision conservation program and a program for detection and prevention of amblyopia. It was recommended that the standards for referral resulting from such programs should be those adopted by the National Society for the Prevention of Blindness.

The Division also agreed with the proposal of the State Board of Health to establish an epidemiological study of blindness.

In connection with its role as a consultant to the State Department of Public Instruction, the Division has agreed to analyze a form used by ophthalmologists in reporting to the Bureau for Handicapped Children. The Bureau has also agreed to compile information on the criteria used for deciding to place a child in a particular education class so that this can be studied by the Division.

The Division also plans to hold some of its future meetings at the schools for the blind and for the deaf at Delavan and Janesville. In addition, meetings will be held at the day centers in Milwaukee and Madison.

Because of the increased activities of the Division and the somewhat separate problems presented by visual defects and by hearing defects, the Division has recommended to the Council that these subject matters be divided.* This would result in a Division on Ear, Nose and Throat and a Division on Vision.

The Division would also like to call to the attention of the Delegates an exhibit on hearing which will be at the Auditorium in connection with the 1967 Annual Meeting. This exhibit was prepared by Employers Insurance of Wausau in cooperation with the Charitable, Educational and Scientific Foundation of the Society and is being exhibited at the request of the Division on Visual and Hearing Defects.

*The Council took action to approve separation into two divisions on March 11, 1967.

Report No. 12

■ REPORT OF COMMISSION ON MEDICAL CARE PLANS—May 1967

E. M. DESSLOCH, M.D., Prairie du Chien, Chairman
ROBERT KROHN, M.D., Black River Falls, Vice-chairman
CHARLES BENKENDORF, M.D., Green Bay
G. W. CARLSON, M.D., Appleton
W. T. CASPER, M.D., Milwaukee
M. D. DAVIS, M.D., Milton
T. J. DOYLE, M.D., Superior
MILTON FINN, M.D., Superior
D. N. GOLDSTEIN, M.D., Kenosha
A. W. HILKER, M.D., Eau Claire
J. H. HOUGHTON, M.D., Wisconsin Dells
D. A. JEFFRIES, M.D., Shawano
P. B. MASON, M.D., Sheboygan
HOWARD MAUTHE, M.D., Fond du Lac
A. J. McCAREY, M.D., Green Bay
R. M. MOORE, M.D., Frederic
E. J. NORDBY, M.D., Madison
R. A. SIEVERT, M.D., Madison
L. O. SIMENSTAD, M.D., Osceola
J. T. SPRAGUE, M.D., Madison
A. H. STAHMER, M.D., Wausau
F. H. WOLF, M.D., La Crosse
W. E. WRIGHT, M.D., Mondovi
F. E. DREW, M.D., Milwaukee, President
H. J. KIEF, M.D., Fond du Lac, President-elect

This is a report of WPS 1966 operations and the most current 1967 information available.

Impact of the Title XVIII and the Title XIX Federal and State programs has been substantial in Wisconsin with many thousands of new beneficiaries becoming eligible for benefits. WPS has made every effort in administration of these new programs to dovetail their provisions with the administrative practices of physicians and other providers of service.

Modern computer equipment has been adapted to program areas of administrative difficulty that became apparent in 1966. These revised machine programs, although not complete, should serve to smooth the administration and rapid claims payment for the new programs.

At the same time, WPS subscribers have continued to receive attention both in the servicing of new business and in the payment of claims for those subscribers who already have WPS contracts. The addition of new personnel and expansion of supervisory staff as needed helps maintain WPS levels of service established in previous years. Continuing sales efforts have resulted in the steady growth of both group and non-group policyholders.

WPS staff, budget and sales goals continue to reflect the interest of the State Medical Society in bringing to Wisconsin residents, through WPS, the best in health insurance that can be made available to them.

The following sections indicate activities in more detail.

I. Federal and State Programs

A. Civilian Health and Medical Program of the Uniformed Services

This program (OCHAMPUS) was previously named Military Dependents' Medical Care Plan. The name was changed when persons retiring from military service were made eligible for benefits effective January 1, 1967. Recent changes also expanded benefits for current beneficiaries under the law.

The establishment of "customary, usual and reasonable" fees is scheduled for negotiation with OCHAMPUS early in 1967.

Information received on January 31, 1967, indicates that OCHAMPUS is retaining the basic format for payment it has used in the past; i.e., an unpublished maximum guide of allowances. Any claims above the guide allowances are reviewed, and if the charge is within the range of "customary, usual and reasonable," they are referred to OCHAMPUS with the recommendation that the charges be paid.

B. Veterans' Administration

The contract to provide hometown care for veterans is renewable on July 1, 1967. Current information is that the contract will continue with a fee schedule which approximates physicians' "customary, usual and reasonable" charges. Efforts continue to negotiate the WPS No Fee Schedule concept with the Veterans' Administration.

C. Medicare Part B—Title XVIII

During the first six months of the program (ending December 31, 1966), 50,000 Medicare claims had been processed and $878,000 in benefits had been paid in the area (outside Milwaukee County) served by WPS. Claims volume from July 1, 1966, through April 30, 1967, is estimated to be approximately 200,000 claims, reflecting benefit payments of approximately $5,000,000. Estimated claims volume for 1967 will be approximately $13,000,000. About 50,000 claims are received monthly; 600,000 annually.

WPS has added 140 employees to handle Medicare claims. Approximately 70 of these are full time with the balance working varying hours of from 3 to 6 per day. Medicare Part B had 17 full-time adjusters assigned as of the first of December 1966. This number will be increased to approximately 50 full and part-time adjusters as of April. Obtaining people to develop into skilled claim adjusters has been a difficult task.

The space problem has been alleviated by assigning the top floor of the Smithback Building (approximately 7,000 square feet) to Title XVIII and expanding Title XIX staff into the ground-level floor (5,400 square feet).

To coordinate administration of related programs, a system of units which jointly handle claims for persons who have dual entitlement to Medicare Part B and the Wisconsin Health Assistance Program (Title XIX) was established. The goal of these trial units, begun early in 1967, is to establish one claim form for persons with dual entitlement and make one payment to the provider. Apportionment of expense to the two programs would take place after the claims processing is completed.

D. Wisconsin Medical Assistance Program

From July 1, 1966, through January 1, 1967, the Title XIX Claims Department processed 171,000 claims in the amount of $2,000,000. Claims are now received at a rate of 75,000 per month and payments averaged $1,000,000 monthly.

Claims are processed by 75 employees located in the building on the South Madison Beltline. The Title XIX program will continue through 1967 with no changes currently anticipated.

A Title XIX Claim Manual was forwarded to approximately 7,200 providers in December 1966. Since then a supply of approximately 1,000,000 claim forms have been distributed by WPS to all categories of providers.

II. WPS Operations

A. Enrollment

Group and non-group enrollment gains continued through December. As of January 1, 1967, enrollment benefit units in force totaled 332,971. (Benefit units are counted on the basis of one unit for each surgical–medical subscriber, one for each hospital subscriber and one for each Major Medical subscriber.)

Enrollment growth by categories is shown below:

	Benefit Units	
	12-31-65	12-31-66
Surgical-Medical	141,879	159,965
Hospital	69,162	92,391
Major Medical	45,114	80,615
Totals	256,155	332,971

Total persons (includes all family members) covered by WPS and those eligible for State and Federal programs serviced by WPS are as follows:

WPS Participants	415,118
Medicare Part B	315,000
Wisconsin Medical Assistance Program	125,000

Sales efforts included a group offering for the new Home Care policy. Home Care pays benefits of up to $300 monthly (from $2 to $10 per day) for a full year to the subscriber while totally disabled following a hospital confinement of five or more consecutive days.

The Miscellaneous Expense Endorsement was also emphasized for group sales. This program provides a daily cash benefit of from $2 to $10 per day for the subscriber or his dependents while hospitalized and if desired by the purchaser of a "lump sum" benefit at time of discharge.

Emphasis was also placed on the sale of the Oral Surgery Endorsement designed to pay benefits for oral surgery performed by Doctors of Dental Surgery. Continuing promotion was also concentrated on the Prepaid Dental Care Plan, a program which provides benefits for a broad range of dental services subject to a deductible or no deductible as chosen by the group.

B. Sales Force

The WPS sales force now contains 22 group representatives and 5 agency supervisors in 6 district offices serving all areas of Wisconsin. Sales goals anticipate an earned premium growth of $2,500,000 in 1967. Premium volume for 1966 was $19,460,000.

C. Claims—WPS

Claims incurred in 1966 totaled $16,500,000 or 86 cents of each premium dollar. Claims incurred in 1965 totaled $15,502,834 or 87.6 cents of each premium dollar. Reflecting expansion of sales, the number of claims paid has also continued to increase:

1963	182,030
1964	191,386
1965	211,495
1966	223,000

D. Financial

A financial statement through November 1966 is shown as Exhibit 1 of this report. Some highlights are:

WPS premium volume is budgeted at $22,000,000 for 1967, an increase of approximately $2,500,000 or 13% over the 1966 total of $19,460,000.

The total administrative cost of government programs in 1967 should approximate $1,750,000, of which $1,130,000 is payroll expense. These programs are currently administered on a cost basis.

WPS investments have increased from a total of $7,100,000 at the beginning of the year to a November 1966 total of $8,900,000. This addition consists of unearned premium plus amounts added to reserves.

General reserves were increased by $460,000 through November.

Administrative expenses were maintained at an acceptable ratio to premium income.

E. Administrative

Staff—450 people (includes full and part time) are assigned to various WPS activities, including Title XVIII and Title XIX activities.

Space—action in 1966 provided an additional 12,400 square feet in the building on the Beltline to accommodate the growth of Medicare and Wisconsin Medical Assistance Program staff. Except for 45 employees of the Underwriting and Billing Departments located in the former church on East Lakeside, all employees assigned to the WPS Health Insurance function are currently located in the main building.

F. District X Meeting

The Annual Meeting of the District X Blue Shield area (including North Dakota, South Dakota, Iowa, Nebraska, Minnesota, Wisconsin, Manitoba and Saskatchewan) will be held this fall or early 1968 at State Medical Society Headquarters in Madison. Approximately 50 representatives from the Blue Shield Plans listed are expected to visit the Home of Wisconsin Medicine for two days.

G. Communications

Imaginative communications programs begun in 1967 will be continued throughout the year to emphasize WPS policy features not generally available. Newspaper, magazine and radio ads are designed to appeal to younger elements of the population in all areas of Wisconsin, as well as maintaining a continued promotional effort in acquainting people with the benefits of the WPS Medicare-PLUS $15,000 policy, which has now been sold to approximately 30,000 Wisconsin residents age 65 and over. Further efforts are designed to acquaint people reaching age 65 that enrollment in the WPS supplementary plan is available on the same basis as is their opportunity to enroll in the Federal Medicare Part B program.

Continued efforts are being made by developing and publishing updated claims and other informational manuals on Title XIX, Title XVIII and WPS programs. These will supplement manuals and other materials already provided the profession and medical assistants to ease the administration of the various Federal, State and WPS programs. Another series of meetings for medical assistants throughout the state is being planned.

III. Summary

A review of this report makes it quite apparent that a substantial amount of staff time had to be involved in the implementation of Medicare Part B and Title XIX programs. This additional workload began as early as February 1966 through staff study groups.

The employment of in the neighborhood of 200 additional staff people within a brief period of time presented unique and difficult problems. The interview time required, extensive training courses, and close supervision of new employees had a very real impact on total operations.

The administrative regulations issued by the Social Security Administration are voluminous. Their interpretation and application to daily processing requires a substantial amount of personnel time. The preparation of computer programs and their testing required our scheduling computer operations on a 24-hour basis, 5 days a week, and with additional shifts on Saturday and Sunday to supplement where inventories developed. As programs were written and placed on the computer, they had to be revised to the extent changes were issued by SSA.

The problem has not been unique to Wisconsin. It has been one of national concern. All carriers across the country have received a rapidly increasing volume of cases within a short period of time. Currently, WPS is processing approximately 150,000 cases per month resulting in payment of about $3,250,000 monthly. On the basis of a five-day week, this means $150,000 of claim benefits are processed within the office daily. These figures are cited to give you some general indication of the volume involved currently with WPS programs and the two governmental contracts.

The CMCP is pleased to advise the Council that in view of the substantial problem of implementing the government programs, a creditable job was done by the staff. The Executive Committee of the Commission, which usually meets six or more times a year, and the CMCP, which meets quarterly as required, are kept fully informed at each meeting of current developments, not only under WPS operations, but in the administration of government programs as well. As in the past, the Council will be kept informed of developments which should be brought to its attention.

Exhibit 1

WPS OPERATIONS REPORT

November 1966

Operating Highlights
Year-to-Date

	1966	1965
Benefit Units in Force	332,174	255,268
Number of Claims Paid	204,232	196,242
Premium Income	$17,699,088	$16,172,298
Investment Income	305,994	230,880
Total Income	$18,005,082	$16,403,178
Claims Incurred	$15,125,964	$14,479,587
Government Programs		
Claims Paid	$ 2,314,729	$ 433,789

CONDENSED STATEMENT OF INCOME AND EXPENSE

	12 Months Ending 11/30/66	% of Prem.	11 Months Ending 11/30/66	% of Prem.	Month of November 1966
Earned Premium	$19,223,425	100.00	$17,699,088	100.00	$1,749,711
Agents Commissions	234,415	1.22	226,242	1.28	40,952
Benefits Incurred	16,449,211	85.57	15,125,964	85.46	1,413,474
Available for Operations and Reserves	$ 2,539,799	13.21	$ 2,346,882	13.26	$ 295,285
Operating Expenses	1,937,434	10.08	1,777,395	10.04	177,168
Net Operating Income	$ 602,365	3.13	$ 569,487	3.22	$ 118,117
Investment and Other Income—Net	332,140	1.73	305,994	1.73	30,054
Added to Reserves	$ 934,505	4.86	$ 875,481	4.95	$ 148,171

ANALYSIS OF PREMIUMS AND BENEFITS

	Earned Premium Income	Benefits Incurred	Benefits Incurred as % of Income
Twelve Months Ending November 30, 1966			
Surgical-Medical	$10,843,728	$ 9,344,964	86.18
Hospital	8,379,697	7,104,247	84.78
Total	$19,223,425	$16,449,211	85.57
Twelve Months Ending November 30, 1965			
Surgical-Medical	$ 9,258,169	$ 8,157,124	88.11
Hospital	8,218,592	7,113,288	86.55
Total	$17,476,761	$15,270,412	87.38

CONDENSED BALANCE SHEET—NOVEMBER 30, 1966

WHAT WE OWN:	
Cash	$ 510,584
Receivables	1,006,018
Securities—Lower of Book or Market	8,920,211
Fixed Assets—Net	306,394
All Other Assets	160,077
TOTAL PROPERTIES	$10,903,284
WHAT WE OWE:	
Accounts Payable	$ 80,611
For Unreported and Unpaid Claims	4,650,096
Unearned Premiums	2,292,381
All Other Liabilities	96,200
TOTAL OBLIGATIONS	$ 7,119,288
TOTAL RESERVES	$ 3,783,996

ANALYSIS OF RESERVES

	Month of November 1966	11 Months Ending 11/30/66
Beginning Reserves	$3,642,332	$3,323,686
Add: Provided by Opr. & Invest.	148,171	875,481
(Decrease) in Value of Securities	(6,507)	(415,171)
ENDING RESERVES	$3,783,996	$3,783,996

Report No. 13

REPORT OF COMMISSION ON PUBLIC POLICY —May 1967

W. T. RUSSELL, M.D., Sun Prairie, Chairman
C. F. BRODERICK, M.D., Wisconsin Dells, Vice-chairman
E. C. QUACKENBUSH, M.D., Hartford
L. W. SCHRANK, M.D., Waupun
T. E. HENNEY, M.D., Portage
J. M. LUBITZ, M.D., Brookfield
L. J. KURTEN, M.D., Racine
K. L. SIEBECKER, JR., M.D., Madison
H. A. PETERS, M.D., Madison
J. V. BOLGER, JR., M.D., Waukesha
J. S. VEUM, M.D., Appleton
R. L. GILBERT, M.D., La Crosse
J. B. DURST, M.D., La Crosse
P. K. ODLAND, M.D., Janesville
S. A. FREITAG, M.D., Janesville
A. D. ANDERSON, M.D., Madison
J. L. TERESI, M.D., Brookfield
DONALD S. SCHUSTER, M.D., Madison
N. G. BAUCH, M.D., Milwaukee
J. A. VAN SUSTEREN, M.D., La Crosse
LYLE EDELBLUTE, M.D., Green Bay
F. E. DREW, M.D., Milwaukee
H. J. KIEF, M.D., Fond du Lac

The Commission on Public Policy reported its long range planning and policy recommendations for the 1967 legislative session to the Interim Session of the House of Delegates held last October. However, several measures have been introduced that were not considered by the House and hence the Commission takes this opportunity to review these and other pending proposals.

In addition, a summary report of legislation that is being followed by the Commission is attached. This report, by necessity, must be continually updated and supplemental information will be presented to the House as it becomes available and in time for consideration at the May meeting.

Bills which are being considered this session and which are being supported by medicine include those dealing with transportation. Legislative proposals calling for chemical testing for intoxication, implied consent, control of motorcycles and testing of drivers for operator's licenses have been endorsed in principle by the Society.

Child abuse legislation has also been considered by the 1967 Legislature and the Society is supporting an amendment to the existing law which would grant civil as well as criminal immunity to physicians and others who make reports of cases of suspected child abuse. At the present time, the physician has immunity from criminal, but not from civil action.

At the direction of the House of Delegates, the Commission has reviewed proposed legislation which would allow a county or group of counties to establish a medical examiner system. Presently, only counties with a population of over 500,000 can establish such a system. The change in the system will require a constitutional amendment because the coroner is a constitutional officer in Wisconsin.

The Commission on Public Policy and the Section on Ophthalmology are also actively supporting legislation which would provide for registration of opticians under the Medical Practice Act instead of under the optometry act where opticianry is now defined. In addition, the Society is also sponsoring legislation initiated by the Section on Ophthalmology, which would require the use of safety glasses in certain academic courses, such as chemistry, industrial arts, etc.

In addition to full Commission meetings, the Executive Committee of the Commission on Public Policy has met several times during the session and has held frequent telephone conferences to decide on the approach the Society should take regarding particular proposals. For example, legislation which would remove birth control information and devices from the present statutory definition which defines them as indecent articles, has received the general support of the Executive Committee of the Commission on Public Policy. The Executive Committee has concurred with the position of the American Medical Association in its statement that the physician must assume a role of leadership in the area of family planning in our present society.

Pending chiropractic proposals include *Assembly Bill 193* which would provide that "no person, other than a licensed chiropractor, shall testify in a professional capacity on a subject relating to chiropractic, for the sickness or injury which is the subject of the judicial inquiry, in any action or proceeding in which he is called as a witness." This legislation and its effect on courts and their rulings on admissibility of evidence is not clear, but apparently the chiropractors are trying to build a fence around their testimony. However, courts have held in the past that when one testifying in court as a member of a licensed body invades the field of another license, then he has opened the door to evaluation of his testimony by the other licensed group. There is no justifiable reason for chiropractors to create confusion in an area which is now clear by court decision.

The Society has also appeared in opposition to a bill which would require Blue Plans to pay for podiatric services or exclude all "foot care" because this would reverse a Supreme Court decision permitting the Blue Plans to control the coverage they want to offer and the benefits they will provide. This legislation would, by necessity, increase the costs of insurance premiums.

A proposal to make measles immunization mandatory has been opposed by the Society on the grounds that mandatory immunization is not the best solution to the problem and that the first order of business is to educate individuals on the danger inherent in the disease. The Society supports a voluntary approach to measles immunization, accompanied with a strong education program. The Council and the House have previously adopted a program of cooperation with the JAYCEES in an educational campaign to eradicate measles.

The Commission in conjunction with the Council has also followed the deliberations of the Kellett Commission since mid-1966. Its representatives have earlier stated publicly that this Commission performed a task of high order in making detailed studies of state government, together with recommendations for its more efficient operation. The Society has officially and publicly approved certain provisions of the bill which involve public health directly. For example, support has been given to the suggestion of creating a central licensing bureau to license trades and professions. However, the Society has gone on record with the position that the functions of the State Board of Health must be maintained if the health of all Wisconsin citizens is to be safeguarded.

Other areas in which the Commission has taken a position include support of a proposal by the Industrial Commission to put all practitioners under the Workmen's Compensation Act so that all radiation devices can be inspected. This would allow protection for all individuals working with radiation. The Commission feels that it is preferable to have the Industrial Commission be the administrative agency in charge of this function rather than ceding inspection of such devices to the federal government.

In the area of drug abuse, the Executive Committee of the Commission has gone on record and in-

structed the Society's legislative representatives to appear in favor of Senate Bill 76 which would control the use of "LSD" by classifying it as a dangerous drug.

In addition, the Commission has sponsored and introduced legislation which would permit residents in hospital training to obtain a renewable one year license, and allow the fees paid to be applied against the permanent licensure fee.

For the information of the Delegates, the subject of osteopathy has received much time, detailed study and consideration by the Council. Assembly Bill 458, which would provide that an osteopath shall not be denied staff privileges solely because he is an osteopath, is being opposed at the direction of the Executive Committee of the Council. This bill could shift the burden of explanation from the applicant to the hospital and the medical staff which has the duty to pass on credentials. At present, it is up to the applicant to satisfy the medical staff and the governing body of the hospital as to his personal and professional qualifications.

The Commission has also opposed a change in the statute of limitations on actions to recover damages for personal injuries. Assembly Bill 330 would provide for a limitation of three years from the time that the person receiving treatment should have reasonably been aware of his injury. The current statutory provision states that the statute of limitations is three years from the date of last treatment. The proposed change would create confusion, and make it difficult to establish the starting time for the statute of limitations.

In addition to working with current legislation, the Commission is continuing its programs in the area of public education, and in accordance with the directions of the House of Delegates, a Conference on Health Fads and Fallacies will be held in Milwaukee next fall.

Exhibit 1

April 11, 1967

To: State Medical Society

MURPHY, HUISKAMP, STOLPER, BREWSTER & DESMOND

MEMORANDUM

Re: Legislative Report as of March 31, 1967

ACTION

Bill	Relating to:	Status
74, A.	Licensing & Equipment of Motorcycles	Hearing held 3/1; Sub. Amendment 1, A. offered 3/9
100, A.	Executive Reorganization	Assembly Amendments 2, 3, 4, 5 and 6 offered
121, A.	Equipment of motorcycle riders	Hearing held 3/1; Amendment 2, A. offered 3/14
135, A.	Licensing of motor driven cycle operators	Hearing held 3/29
143, A.	Measles immunization program	Hearing held 2/28; Assembly Amendments 1 and 2 offered
185, A.	Control of LSD	Hearing held 3/2; Assembly Amendments 3 and 4 and Sub. Amendment 1, A. offered
193, A.	Chiros as expert witnesses	Hearing held 3/7
194, A.	Chiropractic license reciprocity	Hearing held 3/7
195, A.	Chiro educational seminars	Hearing held 3/7
209, A.	Defines LSD as dangerous drug	Hearing held 3/14; Assembly Amendment 1 offered
259, A.	Podiatrists under health insurance	Hearing held 3/23
330, A.	Statute of limitations on malpractice	In committee on Judiciary
333, A.	Podiatrists under Title XIX	In committee on Public Welfare
381, A.	Indecent and contraceptive articles	Hearing held 3/21
399, A.	Resident licenses	Hearing held 3/30
429, A.	Crimes against sexual morality	In committee on Judiciary
458, A.	Osteopathic hosp. staff privileges	In committee on Public Welfare
487, A.	Termination of group insurance	In committee on Ins. & Banking
35, S.	Licensing & equipment of motorcycles	In committee on Highways
55, S.	Executive reorganization	Assembly Amendments 1 through 20 offered
67, S.	Inclusion of LSD in definition of dangerous drugs	In committee on Public Welfare
68, S.	Certification of dispensing opticians	Hearing held on 3/28
76, S.	Control of LSD	Laid temporarily aside
81, S.	Governor's traffic safety bill	Hearing held 3/15
82, S.	Governor's traffic safety bill	Hearing held 3/21
149, S.	Battered child	Hearing held 3/8
241, S.	Indecent & contraceptive articles	Hearing held 3/21

WATCH

20, A.	Compulsory school attendance	Hearing held 3/22
269, A.	Unfair trade practices	Hearing held 3/16
271, A.	Fraudulent packaging	Hearing held 3/16
272, A.	Unfair competition	Hearing held 3/16
274, A.	Fraudulent advertising	Hearing held 3/16
277, A.	Consumer counsel and consumers' advisory committee	Hearing held 3/16
6, S.	Deceptive trade practices	Hearing held 3/30
52, S.	Group health insurance for state personnel	In Joint Committee on Finance
58, S.	Consumer protection and unfair trade practices	Re-hearing held 3/1
148, S.	Safety requirements for deer hunters	Hearing held 3/23
158, S.	Consumer counsel	Hearing held 3/16
159, S.	Fraudulent advertising	Hearing held 3/16
162, S.	Unfair competition	Hearing held 3/16
264, S.	Unfair competition and trade practices	In Com. on Governmental & Veterans' Affairs

INFORMATIONAL

2, A.	Children's code	No action
21, A.	Sale of oleomargarine	No action
30, A.	Air pollution control	No action
52, A.	Tax exemption for nursing and retirement homes	No action
77, A.	Dept. of Administrative investigations	No action
80, A.	Mental examination of accused	No action
99, A.	Governor's budget bill	No action
154, A.	Drivers licenses for epileptics	No action
160, A.	Obscene materials	No action
172, A.	Milw. County medical center	No action
289, A.	Permits for medical alcohol	No action
311, A.	Rights of committed persons	No action
315, A.	Exemption from jury duty	No action
316, A.	State aids for education expenses for brain injured and emotionally disturbed children	No action

Bill	Relating to:	Status
317, A.	Aids for construction and equipment of classrooms for mentally retarded and emotionally distrubed children	No action
322, A.	State aid to mental health facilities	No action
324, A.	Co-ordinating council on mental health and mental retardation	No action
335, A.	Tuition assistance fo Wis. residents	No action
348, A.	Migrant labor camps	No action
359, A.	Colored oleo	No action
388, A.	Emergency commitments	No action
400, A.	1967 segregated fund appropriation	No action
411, A.	Pre-chiropractic education	No action
425, A.	Notification of coroner	No action
446, A.	Tuition assistance	No action
453, A.	Study of mental institutions	No action
456, A.	Advisory hospital council	No action
457, A.	Advisory committee on uniform hospital standards	No action
478, A.	Council on sciences	No action
8, S.	Assignment of injury claims by recipient of public assistance to state, county or municipality	Passed by Senate
10, S.	Open meetings of governmental agencies	No action
15, S.	Creation of Dept. of Urban Affairs	No action
22, S.	Duties, powers and terms of the council for home and family	Passed both houses
78, S.	Obscene materials	No action
80, S.	Legislative scanning council	No action
91, S.	Cruelty to animals	No action
102, S.	Creating an ombudsman	No action
135, S.	Creating a Dept. of Local Affairs & Development	No action
172, S.	Pest control license	No action
174, S.	Colored oleo	No action
202, S.	Aids for construction and equipment of classrooms for mentally retarded and emotionally disturbed children	No action
203, S.	State aids for education expenses for brain injured and emotionally disturbed children	No action
204, S.	Rights of committed persons	No action
205, S.	State aid to mental health facilities	No action

W. P. Horton

Report No. 14

■ REPORT OF COMMISSION ON PUBLIC RELATIONS AND COMMUNICATIONS—May 1967

J. S. DEVITT, M.D., Milwaukee, Chairman
LOUIS OLSMAN, M.D., Kenosha
C. A. OLSON, M.D., Baldwin
C. J. PICARD, M.D., Superior
R. G. HANSEL, M.D., Baraboo
R. R. RUECKERT, M.D., Portage
R. B. BOURNE, M.D., Milwaukee

The Commission met in November 1966 and April 1967. Its activities continue to fall largely into three major categories . . . public information, rural health, and industrial health, each closely interrelated and often indistinguishable. Because all of its activities share a single purpose, that of providing the Wisconsin public with informative material of and for the betterment of its health, the Commission voted, at its last meeting, to recommend to the House that the Bylaws of the State Medical Society be changed to provide a new name for the Commission. The Commission recommends the more descriptive title, "Commission on Health Information."

Methods of disseminating information continue to center around . . .

"*March of Medicine*" radio show, now in its 22nd year (with plans to be made for a silver anniversary celebration in 1970). For seven years the program has been under the direction of H. Kent Tenney, M.D., who personally responded to 250 listeners and sent out 1,276 scripts during 1966. The program is heard by upwards of 350,000 Wisconsinites on 54 radio stations.

News Releases to the 455 newspapers, radio and TV stations in the state—159 releases were distributed in 1966, 34 during the first three months of this year.

Pamphlets, which are requested by a variety of people on an almost limitless number of subjects. The Society encourages young people to seek from us pamphlets on health careers and on health in general, and their increasing reliance on Medicine as the best source of that information is shown in the fact that the majority of the pamphlets mailed out in 1966 went to students.

Films, as well, show an increase in popularity, particularly by physicians and health personnel for use in education and showings before the public. While the Society does not have its own film library, it makes every effort to keep abreast of all available films and to offer extensive information on titles and sources when inquiries are received.

Because the public's increased awareness of medical facts should be encouraged, the Commission feels that those not of the profession who devote their efforts to public health education deserve recognition. The Council has approved bestowing an annual award "to one or more individuals, organizations, firms or industries who, through regular communications media, make an outstanding effort to promote public health. This effort is to be distinct from the normal, commonly accepted business of the honoree." The Commission has chosen the Mobil Oil company and its advertising agency, Doyle, Dane, Bernbach, Inc., as the first recipients, for their outstanding newspaper and TV campaign for automotive safety. The awards will be presented during the Society's 1967 Wisconsin Work Week of Health, October 16–20.

The Commission has also instructed staff to study the methods of bringing to Wisconsin television a weekly program, "Doctors at Work." This program has been utilized with great success by several state medical societies throughout the nation. The series consists of films dramatizing medical problems and produced under careful supervision of physicians, each one incorporating a panel discussion by members of the local medical society in the city in which it is being presented.

Early this year the Commission contacted all county medical societies with suggestions on ways to keep their publics aware of available emergency call services, and stressed the point that the Society's communications staff remains prepared to work with all county societies to continue their highest efforts in the fields of communication, information and public relations.

The Commission has also been advised that the AMA has selected Wisconsin as the site of its 1970 National Rural Health Conference, and will cooperate in every way to make this meeting an outstanding one.

RESOLUTION A

Introduced by: Shawano County Medical Society

WHEREAS, Congress has deemed it necessary to establish standards of mechanical safety for motor vehicles even though it is well recognized that most accidents result from human factors; and

WHEREAS, 330,000 Wisconsin children are transported daily by 5500 school bus drivers; and

WHEREAS, There were 191 accidents in the 1965–1966 school year involving school buses, only one of which was caused by a mechanical failure; and

WHEREAS, Section 40.30 (10) (a) and (d) of the Statutes requires certification of freedom from communicable disease; and further requires the examining physician to recommend the individual as physically suitable for employment without setting forth specific standards for such recommendation; and

WHEREAS, The examining physician has in some instances been faced with the dilemma of establishing his own criteria, which may not coincide with other examiners; now, therefore, be it

Resolved, That the Division on Safe Transportation of the Commission on State Departments be requested to promulgate realistic minimal physical standards to be applied in the certification of school bus drivers, and their adoption by the proper state regulatory authorities be advised.

RESOLUTION B

Introduced by: Section on Urology

The Wisconsin State Urological Society at its annual meeting at Madison, Wisconsin on May 6, 1966, voted unanimously to endorse voluntary nontherapeutic vasectomy as an optional means of contraception and directed that the following resolution be forwarded to the Wisconsin State Medical Society.

The Issue

Is the policy of the Wisconsin State Medical Society as enunciated in the Article on Nontherapeutic Vasectomy, page 25, 1966 Blue Book tenable; does it violate the civil and constitutional rights of anyone in the State of Wisconsin; and, considering the ramifying and weighty influence that this policy has, legally, professionally and socially, does it reflect credit on both the Society and profession?

Aside from noting that religious convictions regarding contraception by any technique at all run all the way from complete approval to total disapproval, any further theological discussion in this context is undesirable. The truth or falsity of any particular doctrine is not at issue.

A Resolution

WHEREAS, Medical ethics, the ideals of the profession and indeed the law itself urges that, in the doctor-patient relationship the doctor give or arrange for whatever treatment, in his professional judgment is best for his patient; and

WHEREAS, Recent U.S. Supreme Court decisions have indicated an individual's civil rights are violated when he is required by the rules of a public institution to comply with the practices of a creed to which he does not subscribe and which may be in violation of his own conscience, morals or beliefs; and

WHEREAS, In 1965 the U.S. Supreme Court declared the 86 year old Connecticut law that had forbidden birth control clinics and thus attempted to force the public to use only approved birth control techniques; an unconstitutional violation of privacy.

Among a substantial number of the citizens of Wisconsin, the marital relationship between a husband and wife, especially their sexual relationship, is presumed to be the private concern of the parties themselves; and

WHEREAS, The present SMS policy ignores the following points:

Item: Voluntary vasectomy is legal in all 50 states. Except in Connecticut and Utah, where it is limited to reasons of "medical necessity," there are no legal restrictions on the purpose for which the operation may be performed.

Item: The AMA in "Medico–Legal Forms with Legal Analysis" (1961) brings out the point that nontherapeutic voluntary sterilizations, "until declared illegal by the legislature of the physician's state is a matter of individual principle and conscience" and continues "with regard to civil damages sterilization does not present any greater exposure to liability than other medical and surgical procedures alleged to have been negligently performed."

Item: In spite of an estimated 1,500,000 living Americans who have already obtained voluntary contraceptive sterilizations and the 100,000 to 200,000 yearly receiving them, there is no known case on record of a physician losing a suit brought against him when proper consent from the parties had first been obtained.

Item: The Joint Commission on Accreditation of Hospitals has taken an explicitly permissive position on voluntary sterilization.

WHEREAS, The present Wisconsin State Medical Society policy is explicitly published as a guide to the Hospital Boards of Directors, Staffs and the members of the profession; and

WHEREAS, The application of this policy by the above bodies can and occasionally does violate the civil and constitutional rights of at least two categories of citizens of the State of Wisconsin, namely

1. The patients who have decided to limit the size of their families and whose physician decides that surgical sterilization would be the best solution to their particular problem.
2. Their doctors who by this paragraph are prevented from giving their patients what in specific situations may be the best and most reliable treatment, namely vasectomy.

Now, therefore, be it Resolved, That the Wisconsin State Medical Society policy be changed to endorse voluntary nontherapeutic vasectomy as an alternative means of contraception under the same safeguards and controls as are applied to all other surgical operations.

RESOLUTION C

Introduced by: Dodge County Medical Society

WHEREAS, There is still considerable question among physicians about the educational qualifications of osteopaths; and

WHEREAS, Osteopaths have been and probably will continue to make application for hospital staff membership; and

WHEREAS, The Joint Commission on Accreditation of Hospitals has stated that osteopaths admitted to hospital staffs must continue under supervision of a Doctor of Medicine, thereby indicating some question as to their qualifications; therefore be it

Resolved, That the newly appointed Ad Hoc Committee, named by the Planning Committee of the Council to study the Medical Practice Act and related matters, be requested to further investigate educational qualifications of osteopaths in general so that local hospitals may accept or reject applications on a more realistic basis.

■ RESOLUTION D

Introduced by: Racine County Medical Society

WHEREAS, Each hospital is required to staff a Utilization Review Committee; and

WHEREAS, The members of each such committee necessarily make decisions affecting the status of patients; now, therefore, be it

Resolved, That the State Medical Society of Wisconsin seek the passage of state legislation which would provide a physician who serves on a utilization review committee immunity from litigation arising from the activities of such committees.

■ RESOLUTION E

Introduced by: Racine County Medical Society

Resolved, That the State Medical Society of Wisconsin advise the Department of Health, Education and Welfare that the present requirements for certification and recertification have proven highly objectionable, unnecessary, and not to contribute to the quality of medical care; and be it further

Resolved, That the State Medical Society of Wisconsin supports an amendment of the social security act including Title XIX to permit payments without assignments for medical care of a patient.

Report No. 15

■ REPORT OF THE COUNCIL—May 1967

JAMES C. FOX, M.D., La Crosse, Chairman

Attached are minutes of the Council meeting of March 11–12, 1967. Although not yet approved by the Council for official publication, they are provided for information of the House of Delegates. (These minutes were printed in the May 1967 issue at page 234.)

To implement action of the House last October recommending a permanent reference committee on finances, the Council proposes adoption of the following addition to Chapter III, Sec. 4 of the Bylaws, in the listing of committees appointed by the speaker:

"e. On Finances."

The annual necrology report (Exhibit 1) is also attached to this report, as is the membership report for December 31, 1966, prepared by the secretary's office (Exhibit 2).

Also transmitted at this time, with approval of the Executive Committee of the Council, is a supplementary report of the Commission on Medical Care Plans (see end of this report) with reference to a resolution adopted by the House of Delegates a year ago concerning health insurance benefits for outpatient services.

The Council will meet again before the House sessions in May and will no doubt have a further report at that time.

Exhibit 1

NECROLOGY REPORT

The Council reports with sorrow the deaths of the following physicians since the last Annual Meeting. Members of the Society are indicated in italics.

B. O. Jones, M.D., Racine
J. P. Edwards, M.D., Florence
K. A. Morris, M.D., Merrill
H. M. Kay, M.D., Madison
D. E. Dorchester, M.D., Sturgeon Bay
K. R. Icks, M.D., Green Bay
L. A. Pechous, M.D., Kenosha
S. F. Brusky, M.D., Green Bay
O. F. Guenther, M.D., Oshkosh
W. F. Elders, M.D., De Pere
E. W. Miller, M.D., Milwaukee
E. B. Keck, M.D., Washington, D.C.
A. W. Bryan, M.D., Madison
P. S. Herzog, M.D., Los Angeles, California
H. G. Brehm, M.D., Racine
L. H. Hirsh, M.D., Milwaukee
Hugh Wilson, M.D., Lake Forest, Illinois
R. L. MacCornack, M.D., Whitehall
E. F. Dorzeski, M.D., Antigo
F. N. Nimz, M.D., Milwaukee
W. J. Smiles, M.D., Ashland
E. R. Krueger, M.D., Hayward
H. G. Scheid, M.D., Lakewood, Colorado
J. C. Brewer, M.D., Jefferson
G. K. Tallmadge, M.D., Milwaukee
A. W. Burek, M.D., Marquette, Michigan
W. B. Campbell, M.D., Waukesha
M. K. Rosenbaum, M.D., Cudahy
J. P. Fetherston, Sr., M.D., Milwaukee
J. J. McCarthy, M.D., Green Bay
F. A. Gruesen, M.D., Peoria, Illinois
S. W. Simonson, M.D., Chetek
J. E. Forsyth, M.D., Winnebago
R. O. Brunkhorst, M.D., Milwaukee
E. F. Daley, M.D., Manawa
G. P. Dempsey, M.D., South Milwaukee
L. A. Seymer, M.D., Milwaukee
P. C. Gatterdam, M.D., La Crosse
E. M. Juster, M.D., Madison
M. V. Overman, M.D., Neillsville
B. I. Pippin, M.D., Plantation Key, Florida
A. I. Rosenberger, M.D., Santa Barbara, California
H. L. Doeringsfeld, M.D., Platteville
P. H. Ludden, M.D., Madison
F. O. Brunckhorst, M.D., King
Salvatore Randazzo, M.D., Wauwatosa
Norman Franken, M.D., Havre, Montana
Joseph Hudek, M.D., Waupaca
G. J. Hathaway, M.D., Santa Fe, New Mexico
J. P. Kelly, M.D., Pewaukee
H. R. Ausman, M.D., Milwaukee
P. H. Gutzler, M.D., Dallas, Texas
C. F. Burke, M.D., Madison
A. Z. Domine, M.D., Middleton
A. J. Hockett, M.D., Mosinee
W. C. McCormick, M.D., Tomahawk
E. J. Brown, M.D., Fort Lauderdale, Florida
L. E. Rothman, M.D., Milwaukee
H. S. Schumacher, M.D., Milwaukee
A. B. C. Bock, M.D., Sheboygan

Exhibit 2

STATE MEDICAL SOCIETY OF WISCONSIN

MEMBERSHIP REPORT—DECEMBER 31, 1966

Totals by Classification

Regular	3,592	
Associate	76	
Affiliate	56	
Life	67	
Military	43	
Educational	35	
Career Appointment	16	
SUBTOTAL FULL-PAID MEMBERS		3,885
Resident		117
Honorary		6
Special Service		2
GRAND TOTAL		4,010

MEMBERSHIP REPORT

State Medical Society of Wisconsin

TOTAL MEMBERSHIP BY COUNTY

December 31, 1966

County Medical Society	Regular	Associate	Affiliate	Life	Military	Educational	Career Appointment	Subtotal Full-Paid Members	Resident	Honorary	Special Service	Grand Total
Ashland-Bayfield-Iron	17	1						18				18
Barron-Washburn-Sawyer-Burnett	32	1						33	4			37
Brown	126	1	1	3	4			135	2			137
Calumet	8							8				8
Chippewa	25							25				25
Clark	12	1						13				13
Columbia-Marquette-Adams	28			1				29	1			30
Crawford	9							9				9
Dane	408	12	5	7	9	19	5	465	30	3		498
Dodge	44	1		1				46				46
Door-Kewaunee	18							18				18
Douglas	22			1				23				23
Eau Claire-Dunn-Pepin	87	5		3				95	2			97
Fond du Lac	70	1		2	4			77				77
Forest	3		1	1				5				5
Grant	28	2		2				32				32
Green	38		1					39				39
Green Lake-Waushara	13	1		1				15				15
Iowa	9			1				10				10
Jefferson	31	1		2				34	1			35
Juneau	6							6				6
Kenosha	72	1	1	1				75	3		1	79
La Crosse	96	3	4	2	1			106	1			107
Lafayette	4		1					5				5
Langlade	12							12				12
Lincoln	15	2						17				17
Manitowoc	49			1	1			51	1			52
Marathon	68		2		1			71				71
Marinette-Florence	18	1		1				20				20
Milwaukee	1,232	20	22	19	11	16	9	1,329	64	3	1	1,397
Monroe	11	1		1			1	14				14
Oconto	9							9				9
Oneida-Vilas	27	2						29				29
Outagamie	91			1	2			94	1			95
Ozaukee	19							19				19
Pierce-St. Croix	29		1	1	1		1	33				33
Polk	20	2	1					23	3			26
Portage	27							27				27
Price-Taylor	12				1			13				13
Racine	115	1	5	4	2			127				127
Richland	12							12				12
Rock	109	4		2				115				115
Rusk	5							5				5
Sauk	21		5		1			27				27
Shawano	15	1						16	1			17
Sheboygan	71	5	2	2				80				80
Trempealeau-Jackson-Buffalo	20	1		1				22				22
Vernon	14	1	1		1			17				17
Walworth	31				1			32				32
Washington	25		1	1				27				27
Waukesha	120	1	1	1	1			124	2			126
Waupaca	19	1						20				20
Winnebago	97	2		3	2			104				104
Wood	73		1	1				75	1			76
TOTALS	3,592	76	56	67	43	35	16	3,885	117	6	2	4,010

SUPPLEMENTARY REPORT OF THE COMMISSION ON MEDICAL CARE PLANS TO THE COUNCIL

E. M. Dessloch, M.D., Prairie du Chien, Chairman

Resolution E of the House of Delegates Session, May 1966, called upon health insurance carriers to provide benefits for diagnostic and other services which can be carried out on an outpatient basis. The Executive Committee of the Council referred it to the Commission on Medical Care Plans for opinion as to its implementation and with the comment that many such services can be provided in a clinic or office as well.

The Commission on Medical Care Plans at its October 1–2, 1966, meeting recorded its support of the Resolution and offered to do what it could to implement it, including the possibility of meeting with the Health Insurance Council.

The Health Insurance Council is a federation of eight insurance associations representing more than seven hundred member companies. The Health Insurance Council serves on behalf of these companies as a central source of information and technical assistance on health insurance to hospitals, physicians and allied health care groups.

The Reference Committee on Resolutions and Amendments to the Constitution and Bylaws in its October 22, 1966, report to the House of Delegates took note that the Commission on Medical Care Plans reported support of the previously adopted resolution urging health insurance carriers to implement provision of benefits for diagnostic services on an outpatient basis and approved of the CMCP pursuing the question with representatives of health insurance carriers to promote the sale of this benefit.

Accordingly, Mr. John Low, Wisconsin Chairman of the Health Insurance Council, met with the Executive Committee of the Commission on Medical Care Plans December 15, 1966. Mr. Low said a meeting had been held recently with a group of representatives of the industry and reported that many companies do incorporate this benefit in major medical contracts and have the benefit available for sale in basic contracts, but indicated there perhaps is not

sufficient emphasis placed on the inclusion of the benefit in the basic programs. Mr. Low stated that the subject was to receive further consideration at a future meeting of the Health Insurance Council and would prepare a report for review prior to the May 1967 meeting of the House of Delegates. This report, received March 22, 1967, is attached (Exhibit A).

Outpatient diagnostic x-ray and laboratory benefits have been and are currently available to employees in WPS groups of three or more employees. The benefit is automatically included in all WPS proposals for groups of ten or more, although purchase is not mandatory.

In accordance with direction provided by the CMCP an outpatient diagnostic x-ray and laboratory benefit direct mail offering will be made to all present WPS Special Service, non-group subscribers. The benefit will also be made available to new WPS non-group prospects. *All* existing Special Service subscribers are insured with respect to outpatient x-ray services associated with surgery or maternity. This coverage is a basic benefit contained in the Special Service contract and provides for the payment of the physician's customary, usual and reasonable charges.

If the Council wishes, the CMCP will have a representative of the Health Insurance Council available to attend the Reference Committee hearing.

Exhibit A

Report on Diagnostic X-Ray and Laboratory Protection Under Insurance Policies—Submitted by: John Low, Chairman, Wisconsin Committee, Health Insurance Council

Discussion

1. All health insurance policies are written on the basis of certain basic assumptions . . .
   a. The physician will recommend the best and most economical care to benefit the patient.
   b. Insurance benefits should be designed to assure that protection is provided for the financially large, serious, illness and to a lesser extent to cover the smaller "nickel" and "dime" expenses. Over the long run the objective is to provide the greatest economical advantage to the indiviual.
   c. There is economical value in providing protection that encourages preventive medicine.

Relating these assumptions to x-ray and laboratory benefits, the insurance industry position has been to encourage individuals (and employers under group contracts) to secure this benefit. The individual (or employer) has the option to purchase these benefits, and while not forced to buy, the advantages of such protection are urged upon the buyer. The benefit can be secured in two ways.

. . . Under Major Medical type policies the charges for x-ray and laboratory expenses are "eligible" charges and are paid in the same manner as any other eligible charges . . . after the deductible has been satisfied. Often in group insurance these policies are written in conjunction with the policy explained below to eliminate the deductible.

. . . Under Basic Health policies protection against the costs of diagnostic x-ray and laboratory services (other than hospital in-patients) is provided as a part of regular medical expense coverage. This then becomes a first dollar benefit.

Diagnostic x-ray and laboratory benefits can be purchased on either a scheduled basis [form distributed to the House but not reproduced here] or on a Blanket Basis for a flat amount of benefit such as $25 or $50 [form distributed to the House but not reproduced here]. The individual (or employer) has his choice.

Problem

The purpose of this report is to provide information on out-patient diagnostic x-ray and laboratory benefits provided under insurance company contracts. The basic question to be answered is:

Are insurance policies (either group or individual) so written as to "force" an individual into the hospital in order to secure diagnostic x-ray and laboratory benefits?

Does the physician have to hospitalize the patient so the patient can secure diagnostic x-ray and laboratory benefits under the provisions of the policy?

The Future

The insurance industry will continue to push hard and diligently so the availability of diagnostic x-ray and laboratory benefits are completely understood by all purchasers of health insurance. Some companies in fact now insist that this protection be purchased on every group health policy written. [Sales pieces distributed to the House but not reproduced here.]

However it must be recognized that the actual decision as to whether this type of protection should be a part of the policy rests with the consumer.

Some employers and some individuals do not feel their insurance dollar is well invested in a type of coverage that provides only a limited benefit.

It is the responsibility of the insurance industry to make this type of protection available and encourage the public to buy it when it is in the public's best interest.

A survey of member HIC companies was made following my meeting with the Executive Committee last fall. All companies surveyed indicated diagnostic x-ray and laboratory protection was available under their policies. The coverage could be purchased on a scheduled or blanket basis . . . although this varied by company. All companies indicated this coverage is sold whenever possible. The figures indicate that a large segment of the population do have this protection available. We will continue through the voluntary system to promote even greater coverage of the population.

It is hoped that in the meantime physicians recognize such protection is available to all who desire it. In the long run a patient who is hospitalized merely to receive x-ray and laboratory benefits when such services could be performed as well in some other facility has created an economic loss to the medical profession, to those who provide medical insurance and to himself.

Extent of Protection

Major Medical Policies: At the end of 1965 there were in the United States 51,946,000 persons with major medical expense protection. These persons have protection against the costs of diagnostic x-ray and laboratory services after the out-of-pocket amount has been paid.

In Wisconsin, 1,061,000 persons were covered under major medical policies.

Note: These policies when written in combination with Basic Health policies eliminate the deductible charge for this coverage.

Basic Health Policies: A survey conducted in 1962 by the Health Insurance Council among 20 leading insurance companies disclosed that at that time 71% of those persons with regular Basic Health

policies had protection against x-ray and laboratory expenses. The proportion probably has risen since that time. At the end of 1965 there were 58,398,000 persons in the United States with regular medical expense protection by insurance companies. In Wisconsin 1,552,000 individuals were so protected.

Based on the above figures, a close estimate is that 1,102,000 persons in Wisconsin had protection against diagnostic x-ray and laboratory expenses under insurance company regular medical expense plans.

It can be seen that a great deal has already been accomplished in making this type of protection a reality.

NOTE: The figures were secured and made available through the Health Insurance Association of America.

■ SUPPLEMENTARY REPORT OF THE COUNCIL —May 8, 1967

JAMES C. FOX, M.D., La Crosse, Chairman

The Council wishes to announce its annual election of members of the Commission on State Departments. T. W. Tormey, Jr., M.D., of Madison, was reelected as general chairman, and W. J. Egan, M.D., of Milwaukee, as vice-chairman. Ten division chairmen were elected:

Aging: George G. Stebbins, M.D., Madison
Ear, Nose, and Throat: Meyer S. Fox, M.D., Milwaukee
Chest Diseases: H. A. Anderson, M.D., Stevens Point
Handicapped Children: John J. Suits, M.D., Marshfield
Maternal and Child Welfare: J. R. Evrard, M.D., Milwaukee
Nervous and Mental Diseases: A. A. Lorenz, M.D., Eau Claire
Rehabilitation: P. A. Dudenhoefer, M.D., Elm Grove
Safe Transportation: J. L. Weygandt, M.D., Sheboygan Falls
School Health: J. C. H. Russell, M.D., Fort Atkinson
Vision: James V. Bolger, M.D., Waukesha

Other appointments approved by the Council are Drs. R. M. Baldwin of Beloit; C. E. Oberdorfer of Racine; and Milton D. Davis of Milton as advisors to the Wisconsin State Medical Assistants Society; and Drs. W. E. Myers, Fond du Lac, and George W. Dean, Milwaukee, to vacancies on the Commission on Public Relations and Communications occurring during the past year.

Report No. 16 of the Division on Nervous and Mental Diseases is transmitted via this supplementary report, as is a supplementary report on legislation by legislative counsel.

A number of additional resolutions for consideration by the House are also transmitted by the Council:

Resolution F recommending commendation of Congressman Clement J. Zablocki for his efforts in reference to H.R. 6561
Resolution G recommending issuance of a commemorative postage stamp honoring William Beaumont, M.D.
Resolution H on the Hart Bill
Resolution I on the AMA disability insurance program
Resolution J on the retirement of George B. Larson
Resolution K on Roy T. Ragatz

Also transmitted are a series of resolutions adopted by the National Education Association and the American Medical Association on the general subject of school health. The Council recommends that the House consider their adoption in such form as it deems appropriate, with referral to the Division of School Health for implementation.

Finally, the Council invites your careful review of a report on osteopathy which summarizes actions of the AMA and the State Medical Society in the past several years and proposes several recommendations which were accepted by the Council and forwarded to the House of Delegates.

Report No. 16

■ REPORT OF DIVISION ON NERVOUS AND MENTAL DISEASES OF COMMISSION ON STATE DEPARTMENTS—May 1967

A. A. LORENZ, M.D., Eau Claire, Chairman
EDWARD E. HOUFEK, M.D., Sheboygan, Vice-chairman
JEAN P. DAVIS, M.D., Milwaukee
KEITH M. KEANE, M.D., Appleton
T. J. NEREIM, M.D., Madison
CHARLES A. WUNSCH, M.D., Green Bay
OTTO A. DITTMER, M.D., Ripon
LE ROY A. ECKLUND, M.D., Madison
FRANCIS M. FORSTER, M.D., Madison
WILLIAM H. HEYWOOD, M.D. Marshfield
J. T. PETERSIK, M.D., Oshkosh
G. B. TYBRING, M.D., Madison
HENRY VEIT, M.D., Milwaukee

Inasmuch as the Division reported at length at the time of the 1966 Interim Session, this report is primarily an updating of more recent activities. The membership of the Division remains unchanged since the last report; however, due to the multiplicity of activities and programs involving those in the area of mental health, the Division requested the appointment of a vice-chairman. The Council appointed Dr. Edward Houfek of Sheboygan.

The Legislative Council has activated its Mental Health Committee pursuant to Senate Joint Resolution 34. Dr. John T. Petersik serves as the Division representative on this committee. The changes contained in J. R. 34, S. include:

> ". . . a study of all present laws relating to the mentally ill, deficient and infirm with a view to systematic and unified codification and to develop such information as will enable the legislature to provide more adequately and efficiently for the protection, health and welfare of these citizens of the state; . . ."

Due to the scope of the study plus the fact that only one of the members of the committee is a named representative of the Medical Society, arrangements have been made for other physicians to attend these deliberations as observers to facilitate reporting to other interested organizations such as Wisconsin Psychiatric Association. Although the Joint Resolution stipulated a report to the 1967 legislature with recommendations, it is rather unlikely that this schedule will be met.

On the matter of terminating the Mental Health Advisory Committee, there is serious question as to whether the purposes for which the committee was created can be served by an Inter-agency Committee on Health and Welfare. While it is recognized that inter-agency coordination is necessary to reduce unnecessary duplication of effort, the Division believes that both non-governmental and medical representation are essential to proper assessment of mental health needs, program planning and evaluation.

Irrespective of the agency which might be developed or designated to continue the functions contained in the original concept of the Mental Health Advisory Committee, it is the consensus of the Division that the following should be stressed:

A. Need for and importance of coordinated planning of health and welfare programs.
B. Essentially of non-governmental voice in programming and planning; including both medical and general citizen representation.
C. Opinion that an Inter-agency Committee on Health and Welfare could not perform the functions outlined in the original concepts of the Mental Health Advisory Committee.
D. Medical (SMS) support for good mental health programs and facilities.

Moreover, since the SMS was among the forerunners in developing the original Advisory Committee, its advice should be sought on a continuing basis—preferably via the medium of appropriate physician membership representation on any committee charged with the responsibility in this important area of activity.

The psychiatrist–county hospital relationship is a matter of continuing concern to the Division. To explore this matter more in-depth and also to attempt to formulate meaningful guidelines for psychiatrists who serve as consultants to county hospitals, a joint committee representing both the Division and the Wisconsin Psychiatric Association has been formed. It has held one meeting and is currently in the process of developing suggested areas where both the privileges and responsibilities of the psychiatrist may be more specifically delineated in his varying consultative roles with county hospitals. The committee is further exploring the question of whether a county hospital (other than Milwaukee) can function as a community hospital.

Psychiatrist–psychologist relationships are of continuing concern. In addition to the psychologists role as a component of the mental health team, there are those who wish to serve as consultants, on an unsupervised basis, in making disability determinations. Moreover, they wish to bill and be paid individually on a fee-for-service basis. In this regard and in response to a request from the Division on Rehabilitation for a policy recommendation, the Division on Nervous and Mental Diseases suggests that a psychologist be paid only through the physician with whom he is a consultant in evaluating disability determinations.

Again this year, the Division was privileged to sponsor a post graduate educational symposium. It was held in Eau Claire on April 5, 1967 and attended by over 200, with the majority of physician registrants representing general practice. In addition to approval of the program content by the Commission on Scientific Medicine and AAGP acceptance for five hours of credit, the 1967 Symposium on "The Geriatric Patient" enjoyed the support of the CESF, the Division of Mental Hygiene of the State Department of Public Welfare, the Wisconsin Psychiatric Institute and also a number of pharmaceutical companies. The latter were acknowledged in the March issue of the *Wisconsin Medical Journal.*

The Division is encouraged by the responses to and reported benefits of these programs and hopes to continue them in the future—perhaps in other areas throughout the state.

The Division was pleased to accept program responsibility for one day of the 1967 Wisconsin Work Week of Health which is scheduled for October 16–20.

In conclusion, the Division encourages all physicians to be alert to mental health problems in their communities and also to become and remain involved in program planning as well as program direction. Such is essential to the end that such programs will be both meaningful to those in need of them and to avoid inappropriate use of mental health professionals and ancillary personnel—all of whom continue to remain in short supply.

SUPPLEMENTARY REPORT ON LEGISLATION

Mr. Robert B. Murphy, Madison, General Counsel

The following is submitted as a summary status report of major state legislation introduced through May 4, 1967, and a supplement to legislative reports made previously to the Society.

As in earlier sessions, the State Medical Society has taken an interest in a wide variety of health issues facing the state legislature. They range from general governmental reorganization to the control of LSD and the similar substances.

Governmental Reorganization

Perhaps the major issue facing the 1967 legislature is the proposed reorganization of the administrative and executive branches of state government. The proposal was developed by the Kellett Commission, a task force appointed by the Governor to look into means of achieving more efficient state government. The concern of the Medical Society for the assured independence of the State Board of Medical Examiners and other health related bodies has been satisfied by appropriate amendment of the bill.

There remains the important area of the future of the State Board of Health. The Society's policy, adopted by the Council last summer is meant to assure that the Board will retain essential autonomy so as best to serve health interests of the entire public. Substantial progress has been made in this area through conferences with the Governor, legislators, and others, followed by a corrective amendment.

As the reorganization bill passed the State Senate the last week of April, and moved to the Assembly, a new Department of Health and Social Services will be established. It will absorb the functions of the present State Board of Health and the State Department of Public Welfare. It will be headed by a board of nine, appointed by the Governor. It will be administered by a director.

The agency now known to you as the State Board of Health will operate as the Division of Health in the new department. All powers, duties and functions of the present Board of Health, including rule-making, licensing, certification and inspection, are vested in the state health officer. He will also be the administrator of the new Division of Health.

The Council on Health, the new name of the present Board of Health, will be continued with the following substantial powers, as a result of the sustained efforts of the Medical Society and others:

1. Approval of the appointment of the State Health Officer.
2. Approval of the advisory and examining bodies authorized by various health statutes.
3. Approval of health administrative rules which have the force of law.
4. Veto power over any proposed relocation of functions now vested in the present State Board of Health.

Additionally the Council on Health will be advisory to the Health and Social Services Board and to the Division of Health.

Unresolved is the question whether federal and state funds for health programs should be handled exclusively by the new Board of Health and Social Services, or whether the Council on Health should retain some area of fiscal responsibility.

Diagnostic Center

Following a recent action by the Joint Finance Committee, which considers and offers recommendations to the Legislature as to the executive budget, two bills have been introduced to discontinue the present Diagnostic Center on the University of Wisconsin campus and replace it with a Children's Consultation Service, which would perform less well defined functions than at present for emotionally and mentally disturbed children. The new Children's Consultation Service would be located at the state hospitals at Mendota and Winnebago. The Diagnostic Center, located in Madison for more than 20 years would be closed. Consistent with its 1965 position, the Society has expressed its belief that the Diagnostic Center as a facility distinct from Mendota and Winnebago and with its now carefuly defined concepts should not be abandoned along with its concept of early detection and early treatment under optimum conditions. The Society has urged a fuller study of this matter by the medical profession of the state before the present Diagnostic Center is closed.

Attached to this report is a copy of a letter sent the members of the Senate Committee on Public Welfare by the Chairman of the Commission on Public Policy.

Insurance Legislation

The field of health insurance, including nonprofit sickness care, is also the subject of legislation introduced this session. One resolution calls for thorough study of the entire health insurance industry, with specific reference to alleged abuses occurring in it. Others would limit the scope and operations of group insurance. Most important, however, is a proposal which would put WPS and all other prepayment sickness care plans under the same type of regulation that commercial companies face. This would convert nonprofit plans into commercial plans. More importantly it would throttle the experimental approach which the nonprofit plans have brought to an area so closely related to health economics.

Bills by Other Groups in the Health Fields

The only proposal introduced to date by the Wisconsin Optometric Association is one to permit the creation of a prepaid optometric care plan. This group has expressed its willingness to accept amendments recommended by the Society to clarify the bill.

Four bills have been introduced by representatives of Wisconsin chiropractors. One would qualify chiropractors as the exclusive expert witnesses for chiropractic treatment. A second would grant a broad form of reciprocity for chiropractic licensure. A third calls for annual chiropractic treatments under the Wisconsin Medical Assistance Statutes, which implement Title XIX of the Federal Medicare Act. The fourth would recognize chiropractic treatments under the Workmen's Compensation Law. Most of these bills are old wines in new bottles, although some of the content is new.

Two podiatric bills have been introduced, one to permit the services of a podiatrist to be made a part of the Title XIX medical assistance program of the state; and the other to require all insurance companies to cover podiatric services. The Society has offered no objection to the first of these bills, but is attempting to defeat the requirement that all health insurance policies must include podiatric benefits. This bill has passed the Assembly, which, at the same time, defeated amendments by the chiropractors to be included in it. The Society will continue its opposition to this bill.

Three osteopathic bills have been introduced, two dealing with advisory committees to the State Board of Health and the third to require that there be no discrimination in hospital staff privileges against one holding an unlimited license to practice medicine and surgery, solely on the ground that he is an osteopathic physician and surgeon.

Abortion Legislation

Three bills have been introduced in the Assembly to relax the present statutory rules on abortion. One would repeal all criminal sanctions against abortion. The other two would broaden the scope of permissible therapeutic abortion. None of these bills has thus far been scheduled for hearing or for action.

Miscellaneous

The Society has taken an interest in the proposed traffic safety program of the Governor, and in other highway safety measures. It is anticipated that legislation in this field will be enacted during this session. The Society has supported proposals that LSD and other hallucinogenic substances be classified as dangerous drugs and it is anticipated that such a measure will be enacted. The Society sponsored a bill to permit installment payments for medical licenses by hospital residents to encourage young physicians to do their residencies in the state, and it is hoped that this measure, too, will be enacted.

The Society has prepared for introduction, hopefully at an early date, a bill creating a special statutory committee to make medical evaluation of procedures which either under existing statutes or proposed legislation would impose mandatory modes of treatment or testing on practicing physicians. The PKU legislation of two years ago was one example of this growing tendency in legislation. The pending measles immunization bill is another. The medical profession favors both types of preventive measures but without mandating an entire profession in an unwarranted and unrealistic manner.

COPY

May 5, 1967

SENATE PUBLIC WELFARE COMMITTEE

Hon. Alex J. Meunier, Chairman
Hon. Holger B. Rasmusen, Vice Chairman
Hon. Walter J. Chilsen
Hon. Norman Sussman
Hon. William C. Hansen

Re: *328, S.*

Dear Senators:

Dr. W. D. Stovall "as a member, and later chairman, of the State Board of Public Welfare, was instrumental in planning for the Diagnostic Center and its erection on the University of Wisconsin campus. *This branch of the public welfare services has been filling many serious gaps in the diagnosis of difficult cases among our young people.*"*

The State Medical Society has made known its position as long as two years ago on proposals to phase out the Diagnostic Center and the current proposal to obliterate it as an independent activity and associate it with mental institutions.

The center provides a consultive care to counties and to physicians as well as to patients. For the most part, these youngsters are under 16 years of age, the majority currently under 10. They are posing problems of behavioral adjustment but they are not mental cases. They are not such cases as should be associated with state mental institutions.

The statement by Emeritus Professor Clark quoted above is an up-to-date judgment of a twenty-year achievement. There are many pending and present developments in the entire field of mental health of such magnitude in some respects as to stagger the imagination.

* *The University of Wisconsin Medical School: A Chronical, 1848–1948*, Paul F. Clark, University of Wisconsin Press, 1967.

We urge the State of Wisconsin not to falter in the forward step it took in the creation of the Diagnostic Center. An ounce of prevention is worth several pounds of cure when it comes to mental illness.

Sincerely yours,

/s/ W. T. Russell, M.D., Chairman
Commission on Public Policy

RESOLUTION F

Introduced by: Council, at the request of The Medical Society of Milwaukee County

Whereas, the medical profession believes that the freedom to bill patients directly under Part B of the Social Security Act, commonly called Medicare, is in the best interest of the public and physicians; and

Whereas, the right to bill patients directly under Medicare is a bulwark against government interference in the practice of medicine by restricting the physician's right to treat his patient according to his professional judgment; and

Whereas, the requirement that a paid statement must be submitted by the Medicare enrollee to obtain his benefits has often resulted in financial hardship to the patient; and

Whereas, the Honorable Clement J. Zablocki, Representative from Wisconsin, has recognized the inequities of this requirement in introducing H R 6561 to amend Title XVIII of the Social Security Act to permit an individual to be paid for charges by a physician under the supplementary benefits program prior to the individual's own payment for the charges involved; and

Whereas, this amendment will reaffirm the physician–patient relationship and result in faster, more efficient operation of Medicare by correcting one of the deficiencies of the program; therefore be it

Resolved, That the State Medical Society of Wisconsin commend Congressman Zablocki for his efforts in introducing this bill to correct the deficiencies in Title XVIII of the Social Security Act, and be it further

Resolved, That the State Medical Society of Wisconsin recommend full support of H R 6561 by the American Medical Association.

RESOLUTION G

Introduced by: The Council

Whereas, It was while stationed at Ford Crawford, now Museum of Medical Progress and Stovall Hall of Health, in Prairie du Chien, Wisconsin, that Doctor William Beaumont, a military surgeon, completed his pioneering experiments in the physiology of digestion which form the basis of our present day knowledge of the digestive process; and

Whereas, More than one state claims the honor of his fame, including Connecticut, where he was born; Vermont, where he was first licensed; Michigan, where he first examined his patient, Alexis St. Martin in 1822; and Missouri, where he was buried; therefore be it

Resolved, That the State Medical Society of Wisconsin petition the Postmaster General of the United States to issue a commemorative postage stamp honoring Doctor Beaumont on the 150th Anniversary (1822–1972); and be it further

Resolved, That other interested states be asked to join in a campaign for issuance of a Beaumont commemorative stamp in the year 1972.

RESOLUTION H

Introduced by: The Council, at the request of AMA delegation

Whereas, The medical profession has traditionally supported the principle that those who are in need of medical care should have the freedom to be treated by the physician of their choice; and

Whereas, This principle of free choice extends to other aspects and sources of health care such as hospital services, drugs, appliances and devices; and

Whereas, In the furtherance of the broad and basic principle of "free choice" the medical profession views with disfavor any form of exploitation of patients; and

Whereas, No other profession is subject to more stringent disciplines such as provided for in the Medical Practice Acts of the several states; by self-imposed high standards; by the rules of hospital medical staffs; by the constitutions, bylaws and ethical codes of professional medical associations; and the continuing judgment of their peers in all environments in which physicians serve their patients; and

Whereas, Within the framework of their professional organizations and the self-imposed codes there are adequate safeguards at all levels to cope with and correct abuses should they involve member physicians; and

Whereas, In spite of the foregoing and other factors there are continuing attempts in Congress to impose artificial restraints upon the sources of health services under the guise of "Restraint of Trade" proposals which, if enacted, would create hardships for many patients and severely limit their sources of health care supplies; therefore be it

Resolved, That the State Medical Society of Wisconsin join with the American Medical Association and other organizations dedicated to preservation of personal freedom; individual responsibility; continued high standards of medical practice and health care; and to oppose any legislation such as S. 260, 90th Congress, which would impair continued standards of excellence; and be it further

Resolved, That copies of this resolution be transmitted to the American Medical Association and to the entire Congressional delegation of Wisconsin.

RESOLUTION I

Introduced by: The Council, at the request of AMA delegation

Resolved, That the State Medical Society of Wisconsin favors that all possible steps be taken to preserve the Disability Insurance Program of the AMA at the present level of benefits and premiums.

RESOLUTION J

Introduced by: The Council, at the request of AMA delegation

Whereas, Loyal and competent employees are essential to all successful organizations serving the public interest; and

Whereas, It has come to the attention of the State Medical Society of Wisconsin that one of its former associates, Mr. George B. Larson, plans to retire this year from his position as a member of the American Medical Association executive staff; and

Whereas, The State Medical Society of Wisconsin takes justifiable pride in having been a part of his long and productive career with medical and related health organizations, therefore, be it

Resolved, That the Wisconsin Delegation to the AMA, respectfully invite the AMA House of Dele-

gates to join in paying well deserved tribute to George Larson during the regular business of the 1967 Annual Session.

■ RESOLUTION K

Introduced by: The Council

In 1943 Roy T. Ragatz joined the staff of The State Medical Society after 13 years as Assistant Secretary of the Wisconsin Education Association. His immediate responsibility was staffing the educational and scientific activities of the State Society. This included the annual meetings and many related scientific programs.

During his more than 23 years tenure, he has been closely associated with the Commission on Scientific Medicine and has been invaluable in arranging the program for the annual meetings. In addition, he has organized, promoted, and conducted 388 teaching and scientific programs. Other than the 25 annual meetings, this includes 255 Circuit Teaching programs, 30 Industrial Health Clinics, 26 Cancer and Associated programs, 37 Maternal Mortality and Prematurity Institutes and 40 miscellaneous programs. Attendance at these 388 sessions, exclusive of annual meetings, was almost 21,000, of which almost 15,000 were physicians. This represents a prodigious amount of planning and expenditure of boundless energy.

* * *

WHEREAS, the Council has taken cognizance of the appreciation expressed to it by the Commission on Scientific Medicine regarding the splendid service by Roy T. Ragatz to the State Medical Society; now, therefore, be it

Resolved, That the House of Delegates, on behalf of all Wisconsin physicians, extends its sincere appreciation to Roy T. Ragatz for the important role he has played in maintaining the educational and scientific leadership of the Wisconsin medical profession.

■ RESOLUTION

Adopted by Joint Committee on Health Problems in Education, National Education Association and the American Medical Association, February 26, 27, 28, 1967

Local Implementation of Federal Legislation

WHEREAS, Education legislation with health components is currently being implemented at the local level; and

WHEREAS, The implementation of such legislation requires the participation of physicians, dentists, nurses and allied health personnel; and

WHEREAS, Those expected to execute the health components of such legislation should share in planning its execution; therefore be it

Resolved, That local agencies preparing guidelines for education legislation involve the medical, dental, nursing and allied health professions in planning implementation of programs; and therefore be it further

Resolved, That state and local medical societies contact the appropriate educational authorities or other responsible agencies with respect to implementation involving health components.

■ RESOLUTION

Adopted by Joint Committee on Health Problems in Education, National Education Association and the American Medical Association, February 26, 27, 28, 1967

Misuse of Drugs

WHEREAS, The misuse of the many drugs such as the amphetamines, barbiturates, tranquilizers and the misuse of the so-called "harmful substances" such as glue and other similar aromatic products, remains a continuing problem; and

WHEREAS, Juvenile drug arrests have increased tremendously in the past several years; therefore be it

Resolved, That the dangers of misusing and the advantages of correctly using drugs should be taught to all children; and therefore be it further

Resolved, That such education should be a continuing important part of the total curriculum of Health Education.

■ RESOLUTION

Adopted by Joint Committee on Health Problems in Education, National Education Association and the American Medical Association, February 26, 27, 28, 1967

Professional Preparation of All Teachers and Administrators

WHEREAS, It is recognized that some teacher education institutions are to be commended for including the study of health problems, health practices and methods of teaching health in the curriculum required for all teachers and administrators; and

WHEREAS, Numerous teacher education institutions offer such a course of study only on an elective basis; and

WHEREAS, All elementary and secondary teachers and administrators share the responsibility with parents and their medical advisors for the health education of students; therefore be it

Resolved, That it be a requirement that all prospective teachers and administrators participate in professional courses of health education to qualify for recommendation for certification; and therefore be it further

Resolved, That in-service training programs be offered in the various school districts to supplement and up-date the education of teachers and administrators currently in the profession.

■ RESOLUTION

Adopted by Joint Committee on Health Problems in Education, National Education Association and the American Medical Association, February 26, 27, 28, 1967

Need For Continued Venereal Disease Education

WHEREAS, The overall incidence of venereal disease is decreasing but especially in the 15 to 24 year age group continues to remain at a high level; and

WHEREAS, Continuing educational efforts have proven to be effective when vigorously and continuously applied; therefore be it

Resolved, That all physicians, public health personnel, and other agencies involved in health education continue their efforts toward venereal disease eradication; and be it further

Resolved, That schools, particularly, continue to pursue a vigorous program of venereal disease education as a part of communicable disease instruction in the health education curriculum.

■ RESOLUTION

Adopted by Joint Committee on Health Problems in Education, National Education Association and the American Medical Association, February 26, 27, 28, 1967

Time For Health Instruction

WHEREAS, An increasing number of schools and school systems have succeeded in providing time for the *direct* teaching of health; and

WHEREAS, Providing time for teaching health formerly has been a major roadblock with respect to implementing health instruction as an integral part of the curriculum; and

WHEREAS, Discerning administrators are finding innovative ways of incorporating time for health instruction into flexible daily school schedules; therefore be it

Resolved, That further experimentation in curriculum development and design be carried out with emphasis on innovation in terms of inclusion of direct teaching of health in the curriculum; and be it further

Resolved, That those school administrators who have provided through ingenuity and innovation appropriate time for teaching health be commended for their efforts to assure young people, in our schools, the health instruction they need and deserve.

■ RESOLUTION

Adopted by Joint Committee on Health Problems in Education, National Education Association and the American Medical Association, February 26, 27, 28, 1967

Balanced Curriculum

WHEREAS, It is essential to teach health effectively in all our schools; and

WHEREAS, Each year demands are made upon the schools to emphasize certain more dramatic issues in the health curriculum; and

WHEREAS, We encourage updating and improving the health curriculum; therefore be it

Resolved, That schools be encouraged to be flexible enough to meet the current needs of our times; and be it further

Resolved, That schools make every effort to teach all important aspects of health with the proper emphasis and to discourage an over emphasis on popular problems at the expense of a total balance health education program for children and youth.

■ RESOLUTION

Adopted by Joint Committee on Health Problems in Education, National Education Association and the American Medical Association, February 26, 27, 28, 1967

Consumer Education

WHEREAS, It is important for students to learn to analyze scientifically conflicting claims with respect to health information, products and services; and

WHEREAS, Developing such analytical skills and abilities involves the formulation of personal realistic criteria upon which to base decisions regarding health information, products and services; and

WHEREAS, In a democracy it is important for the schools to have the opportunity to teach objectively about controversial issues; therefore be it

Resolved, That the Joint Committee on Health Problems in Education reaffirm its 1964 resolution on Consumer Education; and be it further

Resolved, That this resolution be widely disseminated through all appropriate channels.

(Note: The 1964 resolution on Consumer Education mentioned above follows.)

RESOLUTIONS

Joint Committee on Health Problems in Education of the N.E.A.–A.M.A., March 30–31, April 1, 1964

Consumer Education

WHEREAS, The American people spend an estimated billion dollars a year on unneeded health and sometimes harmful health and health-related products, and

WHEREAS, Many of today's consumers are unable to discriminate among qualified health personnel, irregular practitioners, and members of the healing cults, and

WHEREAS, Unqualified health cultists and unethical advertisers resort to misinterpretations, misconceptions and misrepresentations to sell their services, and their products, and

WHEREAS, These practices of purchasing unneeded health products, of being unable to discriminate among health personnel, and of believing unethical advertising result in the delay of or in the lack of needed medical care, and

WHEREAS, Carefully organized and properly integrated consumer education, within the health curriculum, could prepare future generations to evaluate critically claims made for health products and health services, therefore be it

Resolved, That the schools in every community incorporate appropriate units on consumer education into their health education programs, and be it further

Resolved, That competency in critical analysis of advertising and ability to discriminate between qualified and unqualified health personnel be the goal of such instruction, and be it further

Resolved, That the American Medical Association and the Food and Drug Administration continue to sponsor periodic conferences on Quackery and Health, and be it further

Resolved, That the resource units currently being developed under the sponsorship of the American Medical Association on consumer education and health be widely distributed and utilized in the nation's schools.

■ REPORT ON OSTEOPATHY*—May 1967

Due to recent and somewhat precipitate developments in the area of those holding the degree of Doctor of Osteopathy and not the degree of Doctor of Medicine, a brief review of these developments seems in order. Without going into full detail, the holder of the degree of Doctor of Osteopathy was permitted full licensure in Medicine and Surgery in 1949.

Many secured the unlimited license through a type of grandfather's clause that permitted them to take a course in materia medica as approved by the State Board of Medical Examiners. The full license was granted following satisfactory completion of that course and the surrender of the old license. All graduates of osteopathic schools applying for license in Wisconsin since that year have received the same examination by the State Board of Medical Examiners as those holding the degree of Doctor of Medicine, and have received the same license if successful in the examination.

There were developments nationally over a period of several years which led the American Medical Association to the conclusion that the professional association of osteopaths with doctors of medicine was no longer a national matter, but one which should be handled at the state level. The House of Delegates of the AMA in 1961 took the following action:

* A Proposal to the Executive Committee relative to osteopathy if and as approved to be forwarded to the Council, and if and as approved there, to be forwarded to the House of Delegates.

1. There can never be an ethical relationship between a doctor of medicine and a cultist, that is one who does not practice a system of healing founded on a scientific basis.

2. There can never be a majority party and a minority party in any science. There cannot be two distinct sciences of medicine or two different, yet equally valid systems of medical practice.

3. Recognition should be given to the transition presently occurring in osteopathy, which is evidence of an attempt by a significant number of those practicing osteopathic medicine to give their patients scientific medical care. This transition should be encouraged so that the evolutionary process can be expedited.

4. It is appropriate for the American Medical Association to *reappraise its application of policy* regarding relationships with doctors of osteopathy, in view of the transition of osteopathy into osteopathic medicine, in view of the fact that the colleges of osteopathy have modeled their curricula after medical schools, in view of the almost complete lack of osteopathic literature and the reliance of osteopaths on, and use of, medical literature, and in view of the fact that many doctors of osteopathy are no longer practicing osteopathy.

5. Policy should now be applied individually at state level according to the facts as they exist. Heretofore, this policy has been applied collectively at national level. The test now should be: Does the individual doctor of osteopathy practice osteopathy, or does he in fact practice a method of healing founded on a scientific basis? If he practices osteopathy he practices a cult system of healing and all voluntary professional associations with him are unethical. If he bases his practice on the same scientific principles as those adhered to by members of the American Medical Association, voluntary professional relationships with him should not be deemed unethical.

There are several methods to evaluate the professional, ethical, and scientific competence of practitioners of medicine. The constituent medical associations shall use the same criteria to evaluate the professional, ethical, and scientific competence of those practicing osteopathic medicine. It might be helpful in addition, to evaluate the professional and scientific competence of a doctor of osteopathy according to his professional education and the type of examination given and the license granted to him by the state in which he practices. It might be possible to establish these standards through the development of state liaison committees of doctors of medicine and doctors of osteopathy. In some states it might be possible to initiate and complete negotiations for the elevation of osteopathic schools to educational equivalence of medical schools according to the standards of the Council on Medical Education and Hospitals.

FROM: Digest of Official Actions, AMA, 1959–1963

This, then, placed the matter squarely before each state medical society. The Council of the State Medical Society of Wisconsin took action in February 1963 which, briefly summarized, cleared the way for Doctors of Osteopathy to be enrolled in various scientific teaching programs which would develop their skills and knowledge in meeting their public health responsibilities. The House of Delegates concurred with the Council action in May 1963.

County medical societies were urged by the Council in 1963 and again in 1964 to review the qualifications and training of osteopaths within their territorial jurisdiction and report their recommendations to the State Medical Society.

In July 1966, importuned by various osteopaths to take more emphatic action because of what seemed to the osteopaths delay at the local level, the Council, on recommendation of a special committee, responded by taking action to accept osteopaths for these various programs without the necessity of local action, and this action was transmitted via the House of Delegates to all county medical societies.

"Voluntary professional relationships between a Doctor of Medicine and a Doctor of Osteopathy should not be deemed unethical if the Doctor of Osteopathy:

"(1) Is currently licensed to practice medicine and surgery under the Medical Practice Act of the State of Wisconsin.

"(2) Practices a healing art founded on the board and all inclusive principles of scientific medicine.

"(3) Does not possess, in addition to his degree of Doctor of Osteopathy and Surgery, the degree of Doctor of Medicine obtained solely by the transfer of credits and not by resident enrollment in an approved medical school.

"(4) Comports himself according to the Principles of Medical Ethics as those Principles have been and will be applied or interpreted from time to time.

"The State Medical Society of Wisconsin will encourage such Doctors of Osteopathy as meet these standards, on the certification of the Wisconsin Association of Osteopathic Physicians and Surgeons, to attend appropriate programs of post-graduate education, and will meet with representatives of the Wisconsin Association of Osteopathic Physicians and Surgeons on matters of mutual interest from time to time."

FROM: Minutes of Council Meeting July 10, 1966

The osteopaths remained unsatisfied.

They wanted more.

They next importuned the State Medical Society and the Wisconsin Hospital Association to take such action at the state level as would permit an osteopath to apply for staff privileges in the hospitals of their community, indicating that their basic desire was to be able to secure consultation, laboratory, x-ray and similar services through the facilities of such institutions.

Such action, necessarily in the form of recommendations to hospital medical staffs, was taken by the State Medical Society through its Council in March 1967, and, during April 1967, in somewhat similar fashion by the Wisconsin Hospital Association.

The secretary and attorneys of the Society feel that the ambitions of at least some Wisconsin osteopaths have not been candidly or fully disclosed in the several years past despite repeated meetings with representatives of this Society, and that this remains the case. If the degree of Doctor of Osteopathy and Surgery is to be equated in a practical fashion with the degree of Doctor of Medicine and Surgery, then it follows that the Doctor of Osteopathy should meet the same professional standards and adhere to the same ethical principles as the medical profession.

The following recommendations are offered to help achieve those ends:

(1) Through cooperation with the State Board of Health there has been a 16 year study of maternal deaths in the high purpose of doing everything possible to engage in postgraduate training and in preventive practices that would hold such deaths to an irreducible minimum. In negotiations with osteopaths it was suggested that their osteopathic hospitals submit to the same study as conducted of those institutions staffed by doctors of medicine. No commitment was offered by the osteopaths, no such study has yet been made, and it is urged that the several osteopathic hospitals in the state immediately offer to participate in such studies and to communicate their willingness to do so to the State Board of Health which licenses them.

(2) Information concerning the academic training, and more particularly such training as may have followed formal educational procedures of osteopathic practice in Wisconsin, is woefully weak in official files. During negotiation osteopaths were urged to provide the State Medical Society with this detailed information so that it could be made avail-

able upon appropriate inquiry by hospitals and by others. The osteopaths have not cooperated with this suggestion. At this point it seems highly imperative that their biographical and professional profiles data be made available. It is hoped that the State Board of Medical Examiners will take immediate steps to make certain that this is done so that information can be released by it with official status.

(3) All members of the Wisconsin Osteopathic Association have been and are now being invited to scientific courses, including those sponsored by official bodies of the state and by the State Medical Society, although this year the Association declined any invitation to the scientific sessions at the Annual Meeting of the State Medical Society since their meeting was scheduled on conflicting dates. The State Medical Society, whose Annual Meeting dates have been established for the next three years, urges the Wisconsin Osteopathic Association to change its annual meeting date so that this conflict will not exist in the future.

(4) One of the basic tenets of the doctor of medicine is that he will give no support and lend no credence to the practice of quackery, and Wisconsin osteopaths are urged to make a similar formal announcement as a tenet of the members of their association. This should be restated as often as necessary, as in the case of those of doctors of medicine.

(5) The Council should state its intent to examine into the professional, ethical and legal implications of formal associations between doctors of medicine and doctors of osteopathy to the same extent that there may be such association between doctors of medicine and surgery. This involves such matters as employment, limited or full partnership, and similar considerations.

■ REPORT OF TREASURER—Year Ended December 31, 1966

F. L. WESTON, M.D., Madison, Treasurer

In accordance with Section 3, Chapter 5 of the Bylaws of our Society, I submit to you my annual report.

As in previous years, I am reporting to you only on those funds which are the direct responsibility of the Treasurer, designated as the Society's "General Fund." Information on financial condition and income and expenditures of related activities of the Society is submitted to you separately, in accordance with a recommendation made to you in October, 1963 by the Reference Committee on Reports of Officers, which you adopted.

The following Exhibits and Schedules make up this report:

Exhibit A—Balance Sheet at December 31, 1966

Schedule A-1—Reconciliation of Net Worth at December 31, 1966

Exhibit B—Statement of Income and Expense—General Fund—Year Ended December 31, 1966

[The above three items also appear in the Consolidated Balance Sheet, which follows, and are not printed here.]

The records of the State Medical Society of Wisconsin have been audited for the year 1966 by Donald E. Gill & Company, Certified Public Accountants. A representative of this firm is present and available for consultation during the course of this Annual Meeting.

■ CONSOLIDATED BALANCE SHEET

December 31, 1966

State Medical Society of Wisconsin and Related Organizations, Madison, Wisconsin

To Council of the State Medical Society of Wisconsin

We have audited the accounts of the State Medical Society of Wisconsin, a Wisconsin Corporation, and accounts of its related organizations, Madison, Wisconsin, for the year ended December 31, 1966. Our examination was made in accordance with generally accepted auditing standards and accordingly included all procedures which we considered necessary in the circumstances, except that it was not practicable to confirm receivables from government departments, as to which we have satisfied ourselves by means of other auditing procedures.

In our opinion the accompanying Balance Sheet and notes which are a part of it presents fairly the financial condition of the State Medical Society of Wisconsin and related organizations at December 31, 1966 in conformity with generally accepted accounting principles applied on a basis consistent (except for the change indicated in Note 1, which change we approve) with that of the preceding year.

/s/ DONALD E. GILL & COMPANY
Certified Public Accountants
Madison, Wisconsin

April 28, 1967

STATE MEDICAL SOCIETY OF WISCONSIN AND RELATED ORGANIZATIONS

CONSOLIDATED BALANCE SHEET

Madison, Wisconsin

December 31, 1966

ASSETS		
Cash	$ 460,797.75	
Current Receivables	1,592,116.72	
Invested Funds, Accrued Interest and Dividends Receivable (NOTE 1)	10,002,290.19	
Student Loans Receivable and Accrued Interest	140,367.52	
Land, Buildings, Equipment and Vehicles—Net Book Value (NOTE 2)	1,185,809.10	
Organization Expense	804.35	
Prepaid Expenses and Deferred Charges	91,043.79	
Long Term Receivables	20,000.00	
TOTAL ASSETS		$13,493,229.42
LIABILITIES, RESERVES AND CAPITAL		
Current Payables, Other Than Benefits	$ 652,819.12	
Mortgages and Debentures Payable	42,500.00	
Deposits Held	92,368.93	
Old Outstanding Checks	10,081.05	
Benefits Payable	4,942,539.09	
Unearned Income	2,384,372.19	
Reserves of Medical Care Plans	4,355,690.37	
TOTAL LIABILITIES AND RESERVES	$12,480,370.75	
Net Worth of General Fund	103,294.22	
Capital of SMS Realty Corporation	283,568.14	
Restricted Principal of Funds	625,996.31	
TOTAL LIABILITIES, RESERVES AND CAPITAL		$13,493,229.42
CONTINGENT LIABILITIES		
Contractual Future Adjustment of Income Under Federal Employee Program		See NOTE 3

Notes one to five inclusive which follow are an integral part of this Balance Sheet.

NOTES

1. Invested funds shown above are included in some cases at book value and in others at market value. In the case of the Pension Plan values on the

books are adjusted annually to market values in accordance with provisions of the Trust Agreement. In the case of Wisconsin Physicians Service, stocks are valued at those market values prescribed by the National Association of Insurance Commissioners, which were, in total, less than book value by $1,478.46. For all other securities of Wisconsin Physicians Service, the amortized cost is used. In previous years, Wisconsin Physicians Service valued bonds and notes at market value. The change to amortized cost resulted in an increase in Reserves on January 1, 1966 of $106,551.17. The securities owned by the Charitable, Educational and Scientific Foundation are shown at book value, which was less than market value on December 31, 1966 by $3,262.46.

2. Fixed assets shown above at book value include those of the Charitable, Educational and Scientific Foundation, some of which are shown at appraisal values.

3. Wisconsin Physicians Service participates in a national program covering Federal employees. Final operating results of the entire program for each contract period are reflected in pro rata allocations to each plan. Information relating to the year 1966 has not yet become final. Adverse results in total operations of the program could occasion an additional liability when this information is known.

4. Certain payables and receivables between the State Medical Society of Wisconsin and its related organizations are eliminated from assets and liabilities above. These are:

Current Accounts	$ 53,451.64
Mortgage Loans	550,957.36
Leasehold Improvements (Shown as Reduction of Fixed Assets of SMS Realty Corporation)	96,031.25
Total	$700,440.25

5. The term, "Restricted Principal of Funds", in this Balance Sheet refers to the Net Worth of those organizations whose funds may be used solely for specifically designated purposes. There is no equity of the State Medical Society of Wisconsin in any of these funds. They are:

- Charitable, Educational and Scientific Foundation, Incorporated of the State Medical Society of Wisconsin
- Student Loan Fund of the State Medical Society of Wisconsin
- Employees' Pension Plan and Trust Agreement of State Medical Society of Wisconsin

RECONCILIATION OF NET WORTH
Year Ended December 31, 1966

	State Medical Society of Wisconsin	SMS Realty Corporation	Restricted Funds	Total
Balance—January 1, 1966	$ 97,343.62	$276,208.10	$569,743.06	$ 943,294.78
Increases	5,950.60	7,360.04	60,298.27	73,608.91
Total	$103,294.22	$283,568.14	$630,041.33	$1,016,903.69
Decreases			4,045.02	4,045.02
Balance—December 31, 1966	$103,294.22	$283,568.14	$625,996.31	$1,012,858.67

The balance sheets and statements of income and expense for separate divisions and related organizations appear in the following order:

- State Medical Society of Wisconsin (General Fund)
- Wisconsin Medical Journal
- Wisconsin Physicians Service
- Military Dependents' Medical Care Plan of the U.S. Government in Wisconsin
- Supplemental Medical Insurance Benefits for the Aged
- Wisconsin Medical Assistance Program
- SMS Realty Corporation
- Charitable, Educational and Scientific Foundation, Incorporated of the State Medical Society of Wisconsin
- Student Loan Fund of the State Medical Society of Wisconsin
- Employees' Pension Plan and Trust Agreement of State Medical Society of Wisconsin

Exhibit A

STATE MEDICAL SOCIETY OF WISCONSIN
General Fund
Madison, Wisconsin
BALANCE SHEET
December 31, 1966

ASSETS		
Current Assets		
Cash on Hand	$ 1,752.96	
Office Petty Cash	340.25	
Cash in Banks	50,364.39	
Accounts Receivable—General	1,257.19	
Due from Employees	700.02	
Due from Charitable, Educational and Scientific Foundation, Incorporated	42,749.78	
Due from SMS Realty Corporation	3,897.66	
Due from Wisconsin Medical Journal	5,916.56	
Due from Wisconsin Physicians Service	62,319.37	
Guaranty Deposit	425.00	
Unexpired Insurance	557.65	
Total Current Assets		$170,280.83
Long-Term Assets		
Loans Receivable		20,000.00
Capital Invested in Divisions		
Wisconsin Medical Journal		18,176.20
Fixed Assets		
Furniture and Equipment	$ 35,989.37	
Less: Accumulated Depreciation	31,567.18	
Total Fixed Assets		4,422.19
Prepaid Expenses and Deferred Charges		
Prepaid Postage	$ 7,937.96	
Inventory of Forms and Office Supplies	5,009.04	
Other Deferred Expense	5,215.90	
Total Prepaid Expense and Deferred Charges		18,162.90
TOTAL ASSETS		$231,042.12
LIABILITIES AND CAPITAL		
Current Liabilities		
Accounts Payable	$ 11,202.40	
Due Employees	635.91	
Dues—Suspense	105.00	
Accrued Payroll Taxes	23,728.80	
Accrued Employees Insurance	1,333.07	
Due Employees Pension Plan	138.11	
Due American International Travel Service	24,870.00	
Accrued Personal Property Taxes	4,054.11	
Total Current Liabilities		$ 66,067.40
Deferred Income		
Prepaid Membership Dues	$ 44,753.00	
Other Prepaid Income	16,927.50	
Total Deferred Income		61,680.50
TOTAL LIABILITIES		$127,747.90
NET WORTH		
Net Worth of General Fund—January 1, 1966	$ 97,343.62	
Additions:		
Increase in Working Capital Advance—Wisconsin Medical Journal $9,525.10		
Excess—Income over Expense—1966 (3,574.50)		
Total Additions	5,950.60	
TOTAL NET WORTH— December 31, 1966		103,294.22
TOTAL LIABILITIES AND CAPITAL		$231,042.12

NOTE: Reserves of Wisconsin Physicians Service, a division of the State Medical Society of Wisconsin, are not included in this statement.

Exhibit B

STATE MEDICAL SOCIETY OF WISCONSIN

General Fund
Madison, Wisconsin

STATEMENT OF INCOME AND EXPENSE
Year Ended December 31, 1966

INCOME		
Membership Dues—Current Year		$361,749.85
Membership Dues—Prior Years		1,184.38
Dues—Section on Medical History		1,730.00
Annual Meeting		26,970.50
Administrative Services		4,282.44
Interest Earned on Invested Funds		3,583.58
Miscellaneous Income		632.14
TOTAL INCOME		$400,132.89
EXPENSE		
Payroll	$167,129.98	
Personnel Services	555.76	
Insurance—Employees	4,923.36	
Retirement Plan Contributions	9,535.74	
Payroll Taxes	4,906.50	
Conference Expense	33,751.93	
Association Dues	1,773.52	
Travel Expense—Staff	16,607.92	
Telephone	3,706.83	
Resource Material	1,470.13	
Printing and Forms	36,525.39	
Postage	12,525.82	
Office Supplies	1,156.87	
Promotion	16,019.82	
Insurance—General	2,528.63	
Grants and Appropriations	5,460.00	
Cafeteria Expense	1,415.91	
Speakers Expense	7,336.48	
Outside Services	16,980.01	
Miscellaneous Expense	4,479.42	
Auditing and Accounting Consultation Services	3,616.50	
Legal Counsel	12,539.84	
Legislative Retainer	8,900.00	
Depreciation	1,646.72	
Rent—Central Office	38,125.00	
Rent—Other	1,652.37	
Rental of Equipment	1,584.75	
Repairs and Maintenance of Equipment	731.15	
Personal Property Tax	535.55	
Total	$418,121.90	
Less: Portion of Above Expense Recovered by Services Furnished to Others	14,414.51	
TOTAL EXPENSES		403,707.39
Excess Income over Expense		($ 3,574.50)

NOTE: The above excess of income over expense for 1966 is closed to Net Worth Accounts as follows:

To Capital Surplus	($ 348.59)
To Section on Medical History	629.20
To Reserve for Budget Carryover	5,334.62
To Unappropriated Surplus	(9,189.73)
Total	($ 3,574.50)

VISIT

MUSEUM OF MEDICAL PROGRESS AND STOVALL HALL OF HEALTH

Prairie du Chien, Wis.

Open until October 31

See details on page 84

Exhibit A

WISCONSIN MEDICAL JOURNAL

A Division of the State Medical Society of Wisconsin
Madison, Wisconsin

BALANCE SHEET
December 31, 1966

ASSETS		
Current Assets		
Cash on Hand and in Bank		$15,737.27
Accounts Receivable—Advertisers		10,977.14
Accounts Receivable—Other		782.59
Copyright Deposits		102.00
Postage Deposits		198.23
Prepaid Insurance		19.92
Total Current Assets		$27,817.15
Fixed Assets		
Furniture and Equipment	$ 1,487.46	
Less: Accumulated Depreciation	893.35	
Total Fixed Assets		594.11
Deferred Charges		
Mailing Envelope Inventory	$ 396.06	
Deferred Blue Book Expense	487.50	
Total Deferred Charges		883.56
TOTAL ASSETS		$29,294.82
LIABILITIES AND CAPITAL		
Accounts Payable	$ 5,202.06	
Due State Medical Society of Wisconsin	5,916.56	
Total Liabilities		$11,118.62
Capital—January 1, 1966	$ 8,651.10	
Add: Excess of Income Over Expense—1966	9,525.10	
Capital—December 31, 1966		18,176.20
TOTAL LIABILITIES AND CAPITAL		$29,294.82

NOTE: The capital of the Wisconsin Medical Journal is carried as a working capital advance among the assets of the State Medical Society of Wisconsin General Fund.

Exhibit B

WISCONSIN MEDICAL JOURNAL

A Division of the State Medical Society of Wisconsin
Madison, Wisconsin

STATEMENT OF INCOME AND EXPENSE
Year Ended December 31, 1966

INCOME			
Advertising Income			$44,301.38
Subscriptions and Supplemental Income			1,061.56
State Medical Society Appropriation			3,000.00
Reprint Income			2,346.09
Miscellaneous Income			5.00
TOTAL INCOME			$50,714.03
EXPENSE			
Direct Payroll		$ 9,427.91	
Printing	$34,299.53		
Less: Costs Recoverable	12,823.50	21,476.03	
Cuts		1,005.00	
Postage		1,768.79	
Rent		875.00	
Reprints		1,976.03	
Editorial Expense		100.00	
Advertising Commissions		37.50	
Advertising Discounts		7.20	
Copyright Expense		72.00	
Telephone and Telegraph		31.17	
Office Supplies and Expense		340.36	
Accounting Services		253.50	
Depreciation		110.01	
Insurance—Employees		538.61	
Insurance—General		62.42	
Legal Services		310.50	
Miscellaneous Expense		349.48	
Printing and Forms		512.94	
Social Security Tax		396.01	
Federal Unemployment Tax		24.00	
Wisconsin Unemployment Tax		28.80	
Retirement Plan Contribution		632.57	
Uncollectible Items		833.10	
TOTAL EXPENSE			41,188.93
EXCESS OF INCOME OVER EXPENSE			$ 9,525.10

Schedule A-1

STATE MEDICAL SOCIETY OF WISCONSIN

General Fund

Madison, Wisconsin

ANALYSIS OF NET WORTH

Year Ended December 31, 1966

	Capital Surplus	Medical History	Wisconsin Medical Journal	Budget Carry-Overs	Unappropriated Surplus	Total
Balance—Jan. 1, 1966	$4,770.78	$2,281.58	$ 8,651.10	$ 8,569.84	$73,070.32	$ 97,313.62
Additions						
Increase in Net Worth of Wisconsin Medical Journal			9,525.10			9,525.10
Excess of Medical History Dues over Expenses		629.20				629.20
Transfers	(348.59)			(4,165.38)	4,513.97	
Excess of General Income over Expenses					(4,203.70)	(4,203.70)
Transfer of 1967 Budget Carry-Overs				9,500.00	(9,500.00)	
Total Additions	($ 348.59)	$ 629.20	$ 9,525.10	$ 5,334.62	($ 9,189.73)	$ 5,950.60
Deductions						
None						
Balance—Dec. 31, 1966	$4,422.19	$2,910.78	$18,176.20	$13,904.46	$63,880.59	$103,294.22
Detail of Budget Carry-Overs:						
Open Panels				$ 7,879.88		
Past Presidents Plaques				2,500.00		
Conference on Health Fads and Fallacies				3,524.58		
Total				$13,904.46		

Exhibit A

WISCONSIN PHYSICIANS SERVICE

A Division of the State Medical Society of Wisconsin

Madison, Wisconsin

BALANCE SHEET

December 31, 1966

ASSETS

Current Assets			
Cash in Office		$ 66,799.91	
Cash in Banks		249,087.99	
Due From Agents		175.47	
Due From Plan Administrator, Federal Employee Program		26,390.51	
Due From Military Dependents Medical Care Plan—Current		5,600.74	
Due From Supplementary Medical Insurance Benefits for the Aged		100,483.15	
Due From Wisconsin Medical Assistance Program		136,698.57	
Premiums Receivable		861,416.00	
Refunds Receivable		17,069.95	
Other Current Receivables		15,754.70	
Unexpired Insurance		3,113.60	
Total			$ 1,482,590.59
Securities (Note 1)		$9,229,225.42	
Bank Deposits at Interest		97,514.33	
Accrued Interest and Dividends Receivable		108,136.92	
Total			9,434,876.67
Total Current Assets			$10,917,467.26
Advances and Other Receivables			
Advances to Medicare (ODMC)		$ 70,813.90	
Mortgage Loans Receivable		550,957.36	
Total Advances and Mortgage Loans			621,771.26
Fixed Assets			
Real Estate, Held as Investment	$103,988.12		
Less: Accumulated Depreciation	8,261.01	$ 95,727.11	
Leasehold Improvements Unamortized		105,459.88	
Office Equipment	$290,492.88		
Less: Accumulated Depreciation	149,532.44	140,960.44	
Automobiles	$ 10,551.27		
Less: Accumulated Depreciation	6,110.19	4,441.08	
Total Fixed Assets			346,588.51
Deferred Charges			
Supplies and Forms Inventories		$ 54,941.73	
Other Deferred Expense		6,615.44	
Total Deferred Charges			61,557.17
TOTAL ASSETS			$11,947,384.20

LIABILITIES AND RESERVES

Current Liabilities		
Accounts Payable	$ 210,642.39	
Due State Medical Society of Wisconsin	62,319.37	
Due SMS Realty Corporation	6,641.59	
Due Plan Administrator, Federal Employee Program	11,000.00	
Accrued Expenses	26,484.29	
Old Outstanding Checks	10,081.05	
Premium Deposits	92,368.93	
Subscriber Benefits Payable, Including Cases in Process or Unreported	4,817,000.00	
Provision for Merit Rating Credits	33,188.52	
Total Current Liabilities		$ 5,269,726.14
Deferred Income		
Premiums Not Earned	$2,321,167.69	
Unearned Administrative Income	800.00	
Total Deferred Income		2,321,967.69
TOTAL LIABILITIES		$ 7,591,693.83
Reserves		
Reserves—January 1, 1966	$3,323,685.50	
Add: Excess—Income Over Expenses—Year 1966	954,185.93	
Adjustment to Bond Valuation (see Note 1)	106,551.17	
Total	$4,384,422.60	
Less: Transfer to Reserve for Market Values of Securities	28,732.23	
Reserves—December 31, 1966		4,355,690.37
TOTAL LIABILITIES AND RESERVES		$11,947,384.20

Contingent Liabilities

Federal Employee Program Income — Note 2

NOTES

1. Stocks are shown at market value, and Bonds and Notes are shown at amortized book value on December 31, 1966. In previous years, Bonds and Notes have been shown at market value. This change resulted in an increase in Reserves by adjustment on January 1, 1966 of $106,551.17.

Stocks were valued at market value by use of valuation data prescribed by the State of Wisconsin Insurance Department. A comparison of valuation of stocks is given below:

Stocks at Book Value	$2,068,306.46
Stocks at Market Value—Insurance Method	$2,066,828.00
Stocks at Market Value—Current Financial Publications	$2,062,619.13

2. Wisconsin Physicians Service participates in a national program covering Federal employees. Final operating results of the entire program for each contract period are reflected in prorata allocations to each plan. Information relating to the period January 1, 1966 to December 31, 1966 has not yet become final. Adverse results in total operations of the program could occasion an additional liability when this information is known.

Exhibit B

WISCONSIN PHYSICIANS SERVICE

A Division of the State Medical Society of Wisconsin

Madison, Wisconsin

STATEMENT OF INCOME AND EXPENSE

Year Ended December 31, 1966

INCOME			
Earned Premium Income, Net of Agents' Commissions			$19,260,638.80
Benefits Incurred			16,683,990.06
Net Underwriting Gain Less Agents' Commissions			$ 2,576,648.74
EXPENSES			
Loss on Operation of Medical Assistance Program		$ 37,422.36	
Joint Plan Expense—Federal Employee Program		354.97	
Payroll		1,118,980.53	
Payroll Taxes		52,766.16	
Retirement Plan Contributions		17,286.98	
Employees' Insurance		45,846.26	
Conference Expense		17,522.29	
Association Dues		11,805.21	
Travel and Auto Rental Expense—Staff		107,345.83	
Telephone and Teletype Service		26,332.05	
Resource Material		2,055.09	
Printing and Forms		63,053.08	
Postage		63,332.89	
Office Supplies		16,380.76	
Promotion		160,569.89	
General Insurance		10,644.32	
Cafeteria Expense		5,663.61	
Miscellaneous Expense		23,505.30	
Auditing and Accounting Consultation Services		9,095.45	
Actuarial Services		9,783.96	
Legal Counsel		29,930.94	
Outside Underwriting Services		7,342.77	
Medical Consultant		4,868.75	
Field Service Expense		6,646.73	
Amortization of Leasehold Improvements		2,736.35	
Depreciation of Equipment		30,281.63	
Rent—Central Office		163,731.42	
Rent—Other Offices		7,156.54	
Rental of Data Processing Copying Equipment		125,016.71	
Maintenance and Repair of Equipment		5,077.79	
Personal Property Tax		3,516.08	
Temporary Help		6,558.31	
Total		$2,192,611.01	
Less: Portions of Above Expenses Recovered by Services Rendered to Others		234,629.05	
Net Administrative Expense			1,957,981.96
Net Gain From Operations			$ 618,666.78
Investment and Other Income			
Interest Earned	$297,861.68		
Dividend Income	37,324.21		
Amortization of Premiums and Discounts	8,984.23		
Rental Income	4,186.45		
Total		$ 348,356.57	
Less: Investment Expenses			
Consultation and Safekeeping	$ 7,670.80		
Expense of Rental Properties	4,496.20		
Loss on Sales of Securities	1,085.29	13,252.29	
Net Investment Income		$ 335,104.28	
Other Income	$ 390.39		
Gain on Sales of Fixed Assets	24.48		
Total Other Income		414.87	
Total Investment and Other Income			335,519.15
Excess Income Over Expense			$ 954,185.93

Exhibit A

MILITARY DEPENDENTS' MEDICAL CARE PLAN OF THE U.S. GOVERNMENT IN WISCONSIN

A Division of the State Medical Society of Wisconsin

Madison, Wisconsin

BALANCE SHEET

December 31, 1966

ASSETS		
Current Assets		
Cash in First National Bank, Madison, Wisconsin	$ 15,023.34	
Cash in Dakota National Bank, Bismarck, North Dakota	8,769.40	
Due From U. S. Government, Office for Dependents' Medical Care	51,615.51	
Due From State Societies—Sub Contracts	978.15	
Suspended Claims	299.33	
Refunds Receivable	323.75	
TOTAL ASSETS		$ 77,009.48
LIABILITIES		
Current Liabilities		
Due Wisconsin Physicians Service—Current	$ 5,600.74	
Due North Dakota State Medical Association	544.84	
Claims Due Physicians, Wisconsin	50.00	
Total Current Liabilities	$ 6,195.58	
Advances		
Advanced Funds—Wisconsin Physicians Service	$ 70,813.90	
TOTAL LIABILITIES		$ 77,009.48

Exhibit B

MILITARY DEPENDENTS' MEDICAL CARE PLAN OF THE U.S. GOVERNMENT IN WISCONSIN

A Division of the State Medical Society of Wisconsin

Madison, Wisconsin

STATEMENT OF INCOME AND EXPENSE

Year Ended December 31, 1966

INCOME		
U. S. Government, Office for Dependents' Medical Care		$ 20,758.14
Indiana State Medical Association		2,033.99
Iowa State Medical Society		1,120.30
Minnesota State Medical Association		1,749.35
South Dakota State Medical Association		641.24
TOTAL INCOME		$ 26,303.02
EXPENSES		
Auditing and Consultation Services	$ 585.00	
Office Supplies and Expense	318.77	
Payroll	11,977.77	
Postage and Express	1,245.57	
Printing and Forms	429.91	
Rent	180.00	
Telephone Services	262.22	
Machine Service Expense	4,501.73	
Overhead Expense	6,438.21	
Legal Services	201.00	
Conference Expense	80.00	
Medical Consulting Service Charge	75.00	
Travel Expense	7.49	
Miscellaneous Expense	.35	
TOTAL EXPENSES		26,303.02
Balance		$ None

SUMMARY REPORT OF 1967 ANNUAL MEETING WITH PICTURES

appeared in June issue at page 13

Council Minutes pertaining to these reports appeared in July issue at page 327

Exhibit A

SUPPLEMENTARY MEDICAL INSURANCE BENEFITS FOR THE AGED

A Division of the State Medical Society of Wisconsin
Madison, Wisconsin

BALANCE SHEET
December 31, 1966

ASSETS		
Current Assets		
Cash on Hand	$ 62.74	
Cash in Bank	21,578.97	
Due From U. S. Government, Social Security Administration	202,595.80	
Prepaid Insurance	1,009.80	
TOTAL ASSETS		$225,248.31
LIABILITIES		
Current Liabilities		
Benefits Due Providers of Service	$124,765.16	
Due Wisconsin Physicians Service	100,483.15	
TOTAL LIABILITIES		$225,248.31

NOTE: The early months of this program have been marked by a failure to receive adequate interpretation of applicable regulations and contract provisions. While this interpretation has improved, the identification and payment of benefits during 1966 may have resulted in duplications or overpayments to beneficiaries, with resultant provision of related funds by the Department of Health, Education and Welfare.

It is not possible to measure, at this time, the extent to which this has occurred. In the normal course of future operations, however, any such duplicate payments or overpayments will be noted, refunds will be requested and amounts will be refunded. It is believed the net effect of such transactions on the above statement are not material.

Exhibit A

WISCONSIN MEDICAL ASSISTANCE PROGRAM

A Division of the State Medical Society of Wisconsin
Madison, Wisconsin

BALANCE SHEET
December 31, 1966

ASSETS		
Current Assets		
Cash on Hand	$ 1,259.38	
Due From State of Wisconsin, State Department of Public Welfare	100,426.73	
Prepaid Insurance	465.66	
TOTAL ASSETS		$402,151.77
LIABILITIES		
Current Liabilities		
Overdraft in Bank Account	$264,679.27	
Due Wisconsin Physicians Service	136,698.57	
Benefits Due Providers of Service	773.93	
TOTAL LIABILITIES		$402,151.77

NOTE: The early months of this program have been marked by a failure to receive adequate interpretation of applicable regulations and contract provisions. While this interpretation has improved, the identification and payment of benefits during 1966 may have resulted in duplications or overpayments to beneficiaries, with resultant provision of related funds by the State of Wisconsin Department of Public Welfare.

It is not possible to measure, at this time, the extent to which this has occurred. In the normal course of future operations, however, any such duplicate payments or overpayments will be noted, refunds will be requested and amounts will be refunded. It is believed the net effect of such transactions on the above statement are not material.

Exhibit B

SUPPLEMENTARY MEDICAL INSURANCE BENEFITS FOR THE AGED

A Division of the State Medical Society of Wisconsin
Madison, Wisconsin

STATEMENT OF INCOME AND EXPENSES
February 11, 1966 to December 31, 1966

INCOME		
U. S. Government, Social Security Administration		$237,011.32
EXPENSES		
Payroll	$117,341.20	
Overhead Expense	54,248.73	
Conference Expenses	770.45	
Travel Expenses	2,924.67	
Provider Relations—Publications	550.00	
Telephone and Telegraph	1,360.74	
Resource Material	185.27	
Printing and Forms	4,933.05	
Postage and Freight	5,784.12	
Office Supplies	1,445.03	
General Insurance	161.20	
Accounting Service	337.35	
Legal Counsel	1,010.00	
Temporary Help	4,317.58	
IBM Machine Rental	286.34	
IBM Machine Time	39,427.46	
Rent	406.83	
Miscellaneous Expense	1,521.30	
TOTAL EXPENSES		237,011.32
Balance		$ None

NOTE: Allowable costs incurred prior to July 1, 1966 for "tooling up" were billed by, and reimbursed directly to, Wisconsin Physicians Service.

Exhibit B

WISCONSIN MEDICAL ASSISTANCE PROGRAM

A Division of the State Medical Society of Wisconsin
Madison, Wisconsin

STATEMENT OF INCOME AND EXPENSES
July 1, 1966 to December 31, 1966

INCOME		
State of Wisconsin, State Department of Public Welfare		$140,686.57
Wisconsin Physicians Service, Administrative Costs Absorbed		37,422.36
TOTAL INCOME		$178,108.93
EXPENSES		
Payroll	$ 60,950.60	
Overhead Expense	27,845.19	
Conference Expense	82.59	
Travel Expenses	862.23	
Provider Relations—Publications	242.00	
Telephone and Telegraph	1,425.02	
Resource Material	156.63	
Printing and Forms	29,767.68	
Postage and Freight	5,636.40	
Office Supplies	4,483.63	
General Insurance	405.34	
Accounting Service	449.80	
Legal Counsel	2,207.02	
Temporary Help	6,826.07	
IBM Machine Time	16,015.34	
Rent	259.21	
Outside Services	17,161.18	
Miscellaneous Expense	3,363.00	
TOTAL EXPENSES		178,108.93
Balance		$ None

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Give to medical education through AMA-ERF

AMERICAN MEDICAL ASSOCIATION
EDUCATION AND RESEARCH FOUNDATION

535 N. Dearborn St.
Chicago 10, Ill.

Exhibit A

SMS REALTY CORPORATION

Madison, Wisconsin

BALANCE SHEET

December 31, 1966

ASSETS		
Current Assets		
Cash		$ 11,080.68
Accounts Receivable		229.88
Due from Charitable, Educational and Scientific Foundation		24.50
Due from Wisconsin Physicians Service		6,641.59
Investments		160,977.94
Cafeteria, Fuel and Supplies Inventory		2,369.93
Accrued Interest Receivable		3,771.26
Unexpired Insurance		345.30
Total Current Assets		$185,441.08
Fixed Assets		
Real Estate—Office Building	$ 875,866.42	
Real Estate—Storage Building	99,168.94	
Other Real Estate	19,691.49	
Automobiles and Equipment	75,950.08	
Total	$1,070,676.93	
Less: Accumulated Depreciation	280,697.66	
Net Book Value	$ 789,979.27	
Less: Leasehold Improvements Paid by Wisconsin Physicians Service	96,031.25	
Total Fixed Assets		693,948.02
Intangible Assets		
Organization Expense		644.35
Deferred Charges		
Prepaid Licenses		104.30
TOTAL ASSETS		$880,137.75
LIABILITIES AND CAPITAL		
Current Liabilities		
Accounts Payable—Trade	$ 10,829.98	
Accrued Property Taxes	23,384.61	
Due State Medical Society of Wisconsin	3,897.66	
Mortgage Notes Payable—Current	9,228.24	
Total Current Liabilities		$ 47,340.49
Long Term Liabilities		
Debentures Payable	$ 7,500.00	
Mortgage Notes Payable $550,957.36		
Less: Current Portion 9,228.24	541,729.12	
Total Long Term Liabilities		549,229.12
TOTAL LIABILITIES		$596,569.61
NET WORTH		
Investment of State Medical Society	$ 150,245.96	
Donated Capital	3,300.00	
Reserves	113,936.89	
Unappropriated Surplus	16,085.29	
TOTAL NET WORTH		283,568.14
TOTAL LIABILITIES AND CAPITAL		$880,137.75

RECONCILIATION OF NET WORTH

Year Ended December 31, 1966

	Balance 1/1/66	Increase from Operations	Balance 12/31/66
Investment of State Medical Society	$150,245.96	$	$150,245.96
Donated Capital	$ 3,300.00	$	$ 3,300.00
Reserves			
For Repair and Maintenance	$ 28,825.70	$ 3,661.04	$ 32,486.74
For Return on Investment	49,520.00	10,000.00	59,520.00
For Funding Appreciation	16,530.15	5,400.00	21,930.15
Total	$ 94,875.85	$ 19,061.04	$113,936.89
Unappropriated Surplus	$ 27,786.29	($ 11,701.00)	$ 16,085.29
TOTAL NET WORTH	$276,208.10	$ 7,360.04	$283,568.14

Exhibit B

SMS REALTY CORPORATION

Madison, Wisconsin

STATEMENT OF INCOME AND EXPENSE

Year Ended December 31, 1966

INCOME		
Rental Income		$193,890.00
Cafeteria Income		40,695.89
Dividend Income		1,312.50
Interest Income		5,024.10
Other Income		250.69
TOTAL INCOME		$241,173.18
EXPENSE		
Legal Services	$ 1,110.93	
Accounting Services	1,085.95	
Managerial Services	6,694.89	
Janitorial and Part-Time Help	30,779.87	
Internal Accounting	2,136.21	
Switchboard Services	5,245.48	
Telephone and Telegraph	11,137.68	
Gas and Light	10,732.20	
Water and Sewer	1,732.04	
Heat	5,434.75	
Building Supplies	7,899.30	
Repairs and Maintenance	6,338.96	
Auto Expense	1,636.31	
Insurance	2,053.45	
Depreciation, Net of Amortization of Improvements	33,923.24	
Interest Expense	27,152.56	
Property Taxes	23,384.61	
Payroll Taxes	2,003.50	
Group Insurance	1,986.49	
Retirement Plan Contribution	1,359.24	
Cafeteria Expense	40,695.89	
Rental Property Expense	325.96	
Amortization of Bond Premium	121.02	
Other Expenses	7,610.54	
Loss on Disposal of Fixed Assets	5,011.64	
TOTAL EXPENSE	$237,592.71	
Less: Portion of Above Expenses Recovered by Services Furnished to Others	3,779.57	
Net Expense		233,813.14
Excess of Income over Expense		$ 7,360.04
Transfer to Reserve for Repair and Maintenance	$ 3,661.04	
Transfer to Reserve for Return on Investment	10,000.00	
Transfer to Reserve for Funding Appreciation	5,400.00	
Transfer to Unappropriated Surplus	(11,701.00)	
TOTAL		$ 7,360.04

Exhibit A

CHARITABLE, EDUCATIONAL, AND SCIENTIFIC FOUNDATION

Incorporated of the State Medical Society of Wisconsin

Madison, Wisconsin

BALANCE SHEET

December 31, 1966

ASSETS			
Current Assets			
Cash on Hand			$ 5,035.15
Cash in Banks			13,431.53
Pledges Receivable			600.00
Dividends Receivable			7.26
Accrued Interest Receivable			979.18
Unexpired Insurance			582.49
Total Current Assets			$ 20,635.61
Long Term Assets			
Notes Receivable—Student Loans	$139,479.78		
Less: Interest of Student Loan Fund in Notes Receivable	1,705.00	$137,774.78	
Common Stocks—Acquisition Value (Market Value $20,531.04)		23,820.61	
U. S. Treasury Bills—Cost (Market Value $19,512.91)		19,475.80	
Savings and Loan Certificates		40,000.00	
Certificates of Deposit		11,000.00	
Total Long Term Assets			232,081.19
Fixed Assets			
Land, Buildings and Equipment—Net			140,256.27
Intangible Assets			
Organization Expense			160.00

Deferred Charges		
Expenses Deferred		1,056.03
TOTAL ASSETS		$394,189.10

LIABILITIES AND CAPITAL

Current Liabilities		
Due State Medical Society of Wisconsin	$ 42,749.78	
Accounts Payable	789.14	
Sales Tax Payable	14.53	
Due SMS Realty Corporation	24.50	
Accrued Interest Payable	80.20	
Total Current Liabilities		$ 43,658.15
Deferred Income		
Advance Receipts—1967 Programs	$ 644.00	
Unallocated Contributions	80.00	
Total Deferred Income		724.00
Funded Liabilities		
Mortgage Notes Payable		35,000.00
TOTAL LIABILITIES		$ 79,382.15

Capital

	Restricted	Unrestricted	
Balance—January 1, 1966	$251,802.80	$ 51,708.44	
Add: Capital Contributions	12,000.00		
Excess—Income over Expense	325.47	(1,029.76)	
Transfers	274.74	(274.74)	
Balance—December 31, 1966	$264,403.01	$ 50,403.94	
Total Capital			314,806.95
TOTAL LIABILITIES AND CAPITAL			$394,189.10

NOTE: Fixed Assets above are shown at values determined by appraisals of real estate and equipment and cost of additions purchased or constructed.

Exhibit B

CHARITABLE, EDUCATIONAL, AND SCIENTIFIC FOUNDATION

Incorporated of the State Medical Society of Wisconsin
Madison, Wisconsin

STATEMENT OF INCOME AND EXPENSE
Year Ended December 31, 1966

INCOME

Contributions		
Restricted as to Use		$39,508.70
Not Restricted		11,028.54
Memorial Contributions		1,900.50
Total Contributions		$52,437.74
Other Income		
Fees for Scientific Teaching Activities	$ 2,684.50	
Museum Admissions	5,799.75	
Sales of Souvenirs and Jewelry	1,563.78	
Interest Income	2,992.52	
Dividend Income	1,857.81	
Miscellaneous Income	123.19	
Total Other Income		15,021.55
TOTAL INCOME		$67,459.29

EXPENSE

Cost of Souvenirs and Jewelry		$ 1,063.15	
Museum Operations		30,630.52	
Charitable Assistance		4,725.00	
Cost of Equipment for Loan		14.00	
AMA-ERF		110.00	
Scientific Teaching		9,435.03	
Project Viet Nam		1,625.00	
Wilson Cunningham Memorial Lecture		1,111.20	
Woman's Auxiliary		846.90	
J. G. Crownhart Memorial		325.00	
General Grants		235.82	
Other than CESF Projects		2,705.05	
General Administration	$ 17,675.39		
Less: Expenses Recoverable	1,738.48	15,936.91	
TOTAL EXPENSE			68,163.58
Excess—Income over Expense (Loss)			($ 704.29)

NOTE: The Foundation classifies separately contributions received for projects in which capital is loaned or invested. Such contributions are not included above for 1966.

CHARITABLE, EDUCATIONAL, AND SCIENTIFIC FOUNDATION

Incorporated of the State Medical Society of Wisconsin
Madison, Wisconsin

GENERAL COMMENTS
OBJECTIVE CLASSIFICATION OF EXPENSE
Year Ended December 31, 1966

Accounting Services	$ 1,288.85
Conference Expense	9,971.90
Promotion	3,143.79
Depreciation	4,247.97
Grants and Appropriations	345.82
Insurance	694.91
Employees Group Insurance	844.40
Legal Services	30.00
Miscellaneous Expense	315.65
Supplies and Expense	222.37
Outside Services	5,513.57
Payroll	22,085.25
Postage and Express	1,505.61
Printing and Forms	1,372.01
Rental of Equipment	167.74
Repairs and Maintenance of Equipment	250.20
Resource Materials	40.11
Speakers Honoraria	700.00
Social Security Tax	781.48
Federal Unemployment Tax	48.32
Wisconsin Unemployment Tax	53.42
Telephone and Telegrams	259.14
Utilities	2,036.38
Travel Expense	742.66
Items for Auxiliary	846.90
Contributions paid out which were designated for other than CESF projects	2,705.05
Building Supplies and Expense	224.37
Interest Expense	2,051.04
Purchases of Jewelry and Souvenirs	1,063.15
Charitable Assistance	6,350.00
Total Expense	$69,902.06
Less: Expenses Recoverable	1,738.48
Net Expense	$68,163.58

STUDENT LOAN FUND

of the State Medical Society of Wisconsin
Madison, Wisconsin

BALANCE SHEET
December 31, 1966

ASSETS

Interest in Notes Receivable—Student Loans	$1,705.00

LIABILITIES AND CAPITAL

Liabilities	$ None
Student Loan Fund Capital	1,705.00
TOTAL LIABILITIES AND CAPITAL	$1,705.00

STATEMENT OF INCOME AND EXPENSE
Year Ended December 31, 1966

INCOME	
None	$ None
EXPENSE	
None	None
Excess Income Over Expense	$ None

Exhibit A

EMPLOYEES' PENSION PLAN AND TRUST AGREEMENT

of State Medical Society of Wisconsin
Madison, Wisconsin

BALANCE SHEET
December 31, 1966

ASSETS

Current Assets	
Cash in Bank	$ 472.79
Accounts Receivable	524.00
Dividends Receivable	347.50

Accrued Interest Receivable			1,389.96
Due from State Medical Society of Wisconsin			138.11
U. S. Government Securities		$ 36,003.74	
Other Bonds		82,081.38	
Preferred Stocks		11,100.05	
Common Stocks		155,703.62	
Total Securities—at Cost		$284,888.79	
Adjustment to Market Value (Reduction)		8,367.04	
Securities at Market Value			276,521.75
Savings and Loan Association Accounts			30,000.00
Total Current Assets			$309,394.11
Deferred Charges			
Deferred Investment Expense			90.25
TOTAL ASSETS			$309,484.36
LIABILITIES AND PRINCIPAL			
Liabilities			$ None
Principal—January 1, 1966		$264,526.82	
Employer Contributions	$42,749.31		
Less: Forfeitures Credited	1,807.28		
Net Amount Contributed	$40,942.03		
Employee Contributions	17,099.72		
Total Net Contributions	$58,041.75		
Fund Earnings (Loss)	(9,039.19)		
Total	$49,002.56		
Less: Payments to Terminating Employees	4,045.02		
Net Increase		44,957.54	
TOTAL LIABILITIES AND PRINCIPAL			$309,484.36

NOTE: Securities are shown above at market value as required by the trust agreement. This treatment has been followed consistently since inception of the trust.

Exhibit B

EMPLOYEES' PENSION PLAN AND TRUST AGREEMENT

of State Medical Society of Wisconsin
Madison, Wisconsin

STATEMENT OF FUND EARNINGS
Year Ended December 31, 1966

INCOME		
Dividends—Common Stocks		$ 4,464.20
Dividends—Preferred Stocks		112.50
Dividends—Savings and Loan Accounts		1,305.00
Total Dividends		$ 5,881.70
Interest Earned		4,491.59
TOTAL INCOME		$10,373.29
EXPENSES		
Investment Counsel Expense	$ 1,015.19	
Loss in Market Values of Securities	18,397.29	
TOTAL EXPENSES		19,412.48
NET FUND EARNINGS (LOSS)		($ 9,039.19)

■ INFORMATIONAL REPORT OF EXECUTIVE COMMITTEE OF BOARD OF TRUSTEES: CHARITABLE, EDUCATIONAL AND SCIENTIFIC FOUNDATION—May 1967

W. D. STOVALL, M.D., Madison, CESF President and Chairman
A. J. McCAREY, M.D., Green Bay, CESF Vice-president
G. J. SCHULZ, M.D., Union Grove, CESF Treasurer
C. H. CROWNHART, Madison, CESF and SMS Secretary
F. E. DREW, M.D., Milwaukee, SMS President
H. J. KIEF, M.D., Fond du Lac, President-elect
J. C. FOX, M.D., La Crosse, SMS Council Chairman
F. L. WESTON, M.D., Madison, SMS Treasurer
R. E. CALLAN, M.D., Milwaukee, Speaker of SMS House of Delegates
J. H. HOUGHTON, M.D., Wisconsin Dells, SMS Past President
R. T. COONEY, M.D., Portage, CESF Trustee *(ex officio)*
L. C. POMAINVILLE, M.D., Wisconsin Rapids, CESF Trustee *(ex officio)*
E. R. THAYER, Waterloo, CESF Trustee *(ex officio)*

The Executive Committee of the Charitable, Educational and Scientific Foundation (CESF) reported activities to the House during its October 1966 session. However, Foundation programs are of a continuing nature in many instances, and the Committee takes this opportunity to update the October report.

The Executive Committee of the Board of Trustees met in January and considered many of the policies guiding the operations and projects of the Foundation. In connection with the Museum of Medical Progress and Stovall Hall of Health (MMP–SHH), which opened on April 15, the Committee decided to seek funds to construct a "Walk In Heart." The Committee has also recommended that an attempt be made to obtain an exhibit dealing with highway safety since this subject has become of increasing interest to the public.

The Wisconsin Anti-Tuberculosis Association has provided funds for the construction of an exhibit tracing the historical development of methods of treatment and modern day prevention of tuberculosis. Present planning calls for this exhibit to be available during this exhibit season.

Highlights of the MMP–SHH opening are summarized in the following news release from the April 12, 1967, Prairie du Chien Courier–Press.

Museum Escapes Flood, Opens 15th

Mountain climbing equipment, used by a woman physician from Wisconsin when she scaled the Himalayas; an audio display, which lets the listener "experience" degrees of hearing loss; and a complete drug store from the late 1800's are among 6,500 square feet of exhibits in the Museum of Medical Progress here which opens for the season Saturday, April 15.

Owned and operated by the Charitable, Educational and Scientific Foundation of the State Medical Society, the three-building Museum complex is located on the site of the old Fort Crawford, a military post built in 1829. The Museum itself is housed in what was the fort hospital, and one wall, known as "Andy Jackson's wall" is the original. Through its windows General Jackson, when stationed there looked out over the camp.

While flood waters came close this year, they failed to reach the high of 1965 which brought the Mississippi within feet of the lowest building, Stovall Hall of Health. That year the old hospital was again put into medical use; displays were pushed aside and Prairie du Chien residents filed in for tetanus shots. The hospital had originally been set on low ground, but was moved higher by military engineers in the 1830's, according to curator Gordon Peckham.

Last year over 23,000 visitors to the Museum traced the history of medical progress in Wisconsin and the midwest, from Indian folklore through the days of the "doctors on horseback," who mixed their prescriptions from herbs carried in their saddlebags ("the nastier the taste, the quicker the cure" one of them observed), to 20th century medicine which promises a healthy life expectancy of 75 years to a child born today in Wisconsin.

This season Mrs. Florence A. Bittner has been added to the staff as consulting curator.

In addition to the operation at Prairie du Chien, the Foundation is continuing its campaign to obtain funds to sponsor the building of a physician's office at Stonefield Village. Stonefield Village is operated by the State Historical Society of Wisconsin and is located in Cassville. At the present time, an "old time" physician's office is the only such exhibit that is missing from the complex which includes an "old time" attorney's office as well as many other exhibits and trades and professions common to early Wisconsin.

The Foundation also provides loan exhibits to many medical and commercial institutions such as banks and hospitals to enable the public to receive health information. For example, the Transparent Twins accomplished another first when they arrived on the Capitol scene amidst the legislative session . . .

The Bohrod paintings have also carried medicine's message to many people during the last several months and are now in their permanent home—the MMP–SHH—for the remainder of the exhibit season. The Transparent Ladies are also in Prairie du Chien vacationland, but are not vacationing since they are a constant attraction for young and old alike.

The Foundation continues its policy of administering not only funds which were donated to it for the purpose of its student loans, but also administering funds for many county societies and individuals who have provided funds for educational scholarships and loans. For example, loan funds from Dane County, Outagamie County, Jefferson County, Trempealeau County and Grant County provide assistance to medical, dental, nursing and pharmaceutical students.

Contributions to the Foundation by physicians, county medical societies, corporations, and interested sponsors are attached for the information of the Delegates as Exhibit A.

As well as administering loan funds, the Foundation has agreed to undertake a project to collect funds from other organizations to support an industrial cardiac research program under the direction of Doctor Hellmuth. Also, the Foundation has decided to set up a separate account for receiving donations from outside organizations if the Section of Ophthalmology of the State Medical Society decides to implement educational programs on proper health care of the eye.

Scientific teaching programs continue their important role in postgraduate medical education. Five "In-Depth" programs have been co-sponsored as a teaching service of the CESF during the last six months. Programs conducted include: Gastroenterology, Renal–Vascular Complications of Pregnancy, Complications of Drug Therapy in Infancy and Childhood, Fractures and Other (Highway) Trauma and Cardiac Emergencies and Intensive Care. These programs, by all indications, were very well received by the members of the profession who were able to take advantage of them.

Reprinted from THE CAPITAL TIMES, Monday, Feb. 13, 1967

Exhibit Here Ends Next Monday

'Transparent Twins' Keep Their Cool in Capitol

While chill winds howl around the Capitol building, think kindly of two "women" who stand in the drafty rotunda day and night, not only unclothed, but without "skin" as well.

Yet no hint of chill creeps into their reception of visitors. The voice one hears is calm, dulcet. Its message is unusual, to say the least, in that citadel of conversation on committee reports and pending legislation: ". . . the pituitary gland, no larger than the end of my little finger, is one of the most powerful organs in my body," or "my arteries, shown in red, carry blood laden with nutrients . . .," the voice announces.

The "women" are better known as the Transparent Twins, an audio–visual exhibit on human physiology which has drawn the sometimes-startled attention of Capitol crowds since late January. It has been placed on display by Wisconsin Physicians Service, the Blue Shield insurance arm of the State Medical Society.

* * *

Using a 12-minute taped message with special lighting effects, the two life sized female figures in the exhibit describe the workings of the organs and nerves, as well as the digestive, reproductive and circulatory systems of the human body.

It was created in 1965 as the only duplicate of one owned by the American Medical Association.

Each of the twins is constructed of two outer shells of transparent plastic. Visible within the shell of one of the models are the major organs of the body. The other details the bony construction and nervous systems.

The twins spend their summers in the Medical Society's Museum of Medical Progress and Stovall Hall or Health in Prairie du Chien, where some 40,000 visitors have seen and heard them in two seasons. During the winter they go on tour; along the Fox River Valley last year; through southern Wisconsin this winter.

They appeared at a Milwaukee school convention before arriving in Madison, and move to the University of Wisconsin Medical Center here when they leave the Capitol building next Monday.

* * *

Then it's back to Medical Society headquarters at 330 E. Lakeside St., where engineer Richard Statz will prepare them for return to the Museum by checking the yards of electrical wiring, the mechanisms which make one model turn on cue, and the intricate synchronization of tape and lighting to coordinate the spoken message with illumination of the part being described.

He will also replace the 12-minute audio tape with a longer version for use in the Museum's sit-down theater during its season.

And if the "ladies" have remained stoic during their cold sojourn in the Capitol, the next few weeks will call for downright heroism: there is no heat at all in the Museum before it opens officially on April 15.

THE DUTCH GAPERS—a part of the health education program of the CES Foundation. Dutch gapers, which ornamented Old World shop fronts in the Netherlands, were at one time the well known shop signs of makers and sellers of medicines. The gapers were supposed to represent the patient. One popular model for these pained or happy faces was the Moor who symbolized the mysterious Far Eastern herbs used in the art of medicine in olden days. Also, Moorish lads were often mustered in as cabin boys when Western ships touched Far East ports, and when the boys landed in Europe they often entered the service of traveling surgeons. With their new masters they went the rounds of fairs and markets, selling medicines. It was the boy's job to distract attention with pantomime and comic faces while the hapless patient swallowed the surgeon's bitter potion. The gapers shown are reproductions. They stand in humorous contrast to our modern serious science of healing the sick. These gapers were constructed especially for the Museum of Medical Progress and Stovall Hall of Health under a grant by Wisconsin Physicians Service.

The foregoing is but a brief summary of the many varied interests and activities of the CESF. If growth is considered a key to success, the Foundation demonstrates success, for not only does the attendance at exhibits at the MMP–SHH and other locations increase each year, but demands for and the establishment of student loan funds is continually increasing.

Contributions from physicians and others support these activities which translate the concern of the profession for making public health knowledge available, and for assisting the medical and paramedical student about to receive training to take his place in the ever growing health field.

All activities, programs and projects of the CESF will be reported, reviewed and considered by the Board of Trustees. The Board is made up of representative members from every county medical society and will meet in Madison in July 1967 to guide medicine's young, but rapidly maturing charitable, educational and scientific arm.

Exhibit A

Contributions to the Charitable, Educational and Scientific Foundation

BY MEMBERS OF COUNTY MEDICAL SOCIETIES

January 1, 1966—December 31, 1966

County	Regular Members	Voluntary Contributions in Response to Billing		Additional Contributions, Memorials, "In Honor of," Ear Marked, Etc.	
		Number	Amount	Number	Amount
Ashland-Bayfield-Iron	17	15	$ 150.00		$
Barron-Washburn-Sawyer-Burnett	32	30	295.00		
Brown	126	94	940.00		
Calumet	8	7	70.00		
Chippewa	25	17	170.00		
*Clark	12	12	120.00		
Columbia-Marquette-Adams	28	27	270.00		50.00
Crawford	9	9	90.00		
*Dane	408	304	3,048.79	3	584.00
Dodge	44	34	340.00	1	20.00
Door-Kewaunee	18	14	140.00		
*Douglas	22	22	110.00		
Eau Claire-Dunn-Pepin	87	64	640.00		
Fond du Lac	70	64	635.00		100.00
Forest	3	2	20.00		
Grant	28	27	270.00		20.00
Green	38	4	40.00	1	10.00
Green Lake-Waushara	13	14	140.00		
Iowa	9	9	90.00		10.00
*Jefferson	31	29	290.00	1	235.00
Juneau	6	6	60.00		
Kenosha	72	70	700.00		45.00
*La Crosse	96	73	745.00		
*Lafayette	4	—0—	—0—		
*Langlade	12	12	120.00		45.00
Lincoln	15	14	140.00		25.00
Manitowoc	49	21	195.00		
Marathon	68	56	560.00		
Marinette-Florence	18	18	180.00		
Milwaukee	1,232	707	7,065.00	6	4,774.55
Monroe	11	12	120.00		
Oconto	9	8	85.00		
Oneida-Vilas	27	20	200.00		
Outagamie	91	71	705.00		19.00
Ozaukee	19	13	130.00		20.00
Pierce-St. Croix	29	20	200.00		15.00
Polk	20	25	250.00		
Portage	27	26	260.00		
Price-Taylor	12	12	120.00		
Racine	115	90	900.00	2	25.00
Richland	12	3	30.00		
Rock	109	69	705.00		
Rusk	5	5	50.00		25.00
Sauk	21	18	180.00	1	15.00
Shawano	15	12	120.00		
Sheboygan	71	36	360.00		25.00
Trempealeau-Jackson-Buffalo	20	22	220.00		
Vernon	14	17	175.00		
Walworth	31	22	220.00	1	15.00
Washington	25	25	250.00		
Waukesha	120	92	930.00		10.00
Waupaca	19	15	150.00	1	10.00
Winnebago	97	74	740.00		50.00
Wood	73	25	245.00		
	3,592	2,507	$24,978.79	17	$6,147.55

*See Contributions By County Medical Societies.

NOTE: In several Counties the number of members making voluntary contributions exceeds the regular members, because members in classifications other than regular also contributed during the year.

BY MEDICAL SOCIETIES

	Amount of Contribution
State Medical Society of Wisconsin	$ 4,885.00
Clark County Medical Society	100.00
Dane County Medical Society	75.00
Douglas County Medical Society	235.00
Jefferson County Medical Society	8,000.00
La Crosse County Medical Society	1,000.00
Lafayette County Medical Society	50.00
Langlade County Medical Society	40.00
Woman's Auxiliary to State Medical Society	913.25
Woman's Auxiliary to Dodge County Medical Society	10.00
Woman's Auxiliary to Grant County Medical Society	40.00
Woman's Auxiliary to La Crosse County Medical Society	18.00

Woman's Auxiliary to Marathon County Medical Society	100.00
Woman's Auxiliary to Outagamie County Medical Society	10.00
Woman's Auxiliary to Waukesha County Medical Society	100.00
	$15,576.25

BY OTHER ORGANIZATIONS AND INDIVIDUALS

American Cancer Society	$ 306.00
CIBA Corporation	500.00
Door-Kewaunee Medical Assistants	25.00
Eli Lilly Company	250.00
Grancare, Inc. Nursing Hospital	50.00
Hoffman La Roche, Inc.	500.00
Lakeside Laboratories	500.00
Marshfield Clinic	250.00
Merck, Sharp and Dohme	2,586.56
Minnesota State Medical Association	100.00
NMC (Nelson Muffler Corp.) Projects, Inc.	250.00
Nelson Muffler Corporation	115.00
Oscar Rennebohm Foundation, Inc.	4,400.00
Parke Davis Company	500.00
Red Arrow Sales Corporation	100.00
Sandoz, Inc.	500.00
Smith, Kline and French Laboratories	300.00
Wallace Laboratories	500.00
W. D. Hoard Foundation	250.00
Wisconsin Anti-Tuberculosis Association	500.00
Wisconsin Heart Association	143.00
Wisconsin Physicians Service	1,175.00
Wisconsin Psychiatric Institute	500.00
Wisconsin Society of Anesthesiologists	100.00
Wyeth Laboratories	500.00
Individuals (Memorial)	697.84
	$12,598.40
GRAND TOTAL	$59,300.99

BY PROJECT

	Amount of Contribution
Donations—General	$14,979.04
Student Loans—General	2,691.30
W. W. Hildebrand, Esquire, Memorial	50.00
Popp Student Loan Fund	2,000.00
Jefferson County Nursing Fund	8,000.00
Wisconsin Academy of General Practice Loan Fund	270.00
Museum of Medical Progress	13,110.25
Museum—Pavilion	500.00
Museum—T. B. Exhibit	500.00
AMA-ERF	110.00
Other than CESF Projects	2,705.05
Speakers Service	2,035.56
Scientific Teaching—General	1,528.54
Charitable—Disabled Physicians	1,600.00
Coin Collection	10.00
J. G. Crownhart Memorial	95.00
Woman's Auxiliary—Indian Affairs	123.00
Woman's Auxiliary—Projects to be Determined	913.25
Tormey Memorial Fund	30.00
Symposium—The Problem Child	5,050.00
Stonefield—Doctor's Office	125.00
Project Viet Nam	1,025.00
Cunningham Memorial Lecture	1,450.00
Elvehjem Memorial Lecture	1,000.00
	$59,300.99

PROCEEDINGS OF HOUSE OF DELEGATES

STATE MEDICAL SOCIETY OF WISCONSIN

ANNUAL MEETING • MAY 8–10, 1967 • MILWAUKEE

MONDAY AFTERNOON SESSION

May 8, 1967

The House of Delegates of the State Medical Society of Wisconsin, meeting at the Sheraton–Schroeder Hotel, Milwaukee, Wis., on May 8–10, 1967, convened at 5 p.m., Drs. R. E. Callan, Speaker of the House, and G. A. Behnke, Vice-speaker of the House, presiding.

APPOINTMENTS TO REFERENCE COMMITTEES

Reference Committee on Reports of Officers

C. J. Strang, M.D., Barron, Chairman
E. D. Sorenson, M.D., Elkhorn
R. E. Urbanek, M.D., Beaver Dam
R. F. Lewis, M.D., Marshfield
G. W. Dean, M.D., Milwaukee

Reference Committee on Reports of Standing Committees

G. W. Hilliard, M.D., Milwaukee, Chairman
W. F. Henken, M.D., Racine
C. E. Koepp, M.D., Marinette
W. E. Myers, M.D., Fond du Lac
J. H. Morledge, M.D., Madison

Reference Committee on Resolutions and Amendments to the Constitution and Bylaws

H. M. Suckle, M.D., Madison, Chairman
F. E. Gehin, M.D., Stevens Point
P. G. LaBissoniere, Milwaukee
C. J. Picard, M.D., Superior
E. P. Rohde, M.D., Galesville

Reference Committee on Finances

A. H. Stahmer, M.D., Wausau, Chairman
L. R. Weinshel, M.D., Milwaukee
R. L. Beilman, M.D., Madison
J. W. McRoberts, M.D., Sheboygan
F. D. Cook, M.D., Green Bay

There is a quorum present. The Credentials Committee will report a little later.

APPROVAL OF 1966 INTERIM SESSION PROCEEDINGS

Speaker Callan: At this time I will entertain a motion to approve the record of proceedings of the 1966 Interim Session as published in a supplement to the December 1966 *Wisconsin Medical Journal.*

Dr. S. E. Zawodny (Milwaukee): I so move.

[Motion seconded and carried unanimously.]

Speaker Callan: The proceedings of the 1966 Interim Session are approved.

■ REPORT OF THE PRESIDENT

Frank E. Drew, M.D., Milwaukee

A year has passed since you honored me by designating me as President of your Society. The honor is the highest acclaim that can be bestowed on a fellow physician. The office of President can carry honor and prestige, but it also has a great responsibility. You are the representative of the medical profession of the State on both local and national levels. You are the consultant to both medical and political medical problems. You are the keeper of the house of medicine.

The House of Delegates in session, a total body of 142 delegates . . .

This task is one of great magnitude today because of its many implications and problems. Alertness is the key to successful operation, and there is no room in the manger for complacency.

I will not burden you again with the many problems that have confronted our profession in the past year. I have attempted to alert my fellow physicians to these problems in my monthly President's Pages.

I personally feel that the profession is keenly alert to these problems, and I am proud of the response to my writing on both local and national levels. I have had communications from all sections of the country expressing appreciation for my efforts. Physicians and laymen who are total strangers have written to me expressing gratitude. This has been my reward. Wisconsin always has been a great leader in the field of medicine, and many people look to us for thought, guidance and leadership. This should always be our course and philosophy.

I will not dwell further on the future of medicine now, but I have grave concern for our liberties if we do not rise to the occasion now, and in the future never accept compromise. We will only be giving away our solemn rights to practice medicine with freedom. That is what the founders of this great country fought for and established as the foundation of our government and democracy. If we are derelict in our duty we can become vassals.

I have traveled from coast to coast attending your meetings and seminars, and I have listened to the "new brand of medicine" and its sugar-coated glories; and it has frightened me to think that our profession can be "sold down the river" by bureaucrats and fellow-physician "do-gooders." These are all organized efforts to undermine the freedom of medicine.

Fortunately, this pill is hard to swallow by many, and I have personally voiced my opinion in objection at these gatherings. A small group of physicians has taken it upon themselves to voice organized opposition. We have a movement afoot to organize the Great Lakes block of states to voice our concerted thoughts on opinions on a national level. Just recently the State of Ohio requested to leave the eastern bloc and join us because they like our brand of medicine.

In a short time the movement has gained great impetus, and we now have an organization of seven states that will rise and declare themselves on a national level. This is a healthy situation, and our voices and rights will be heard with unity. In unity there is always strength.

I am happy to report to you that Wisconsin has been a leader in this new formation, and our fellow states look to us for continued leadership. Medicine can act, medicine can be heard, and medicine can be recognized—but only if we are in the foreground and never in the background. The challenge for survival is here now, and we must meet it.

In closing, I ask that you support organized medicine. Be active in your thinking and expression. Declare your rights to your patients and government. Our patients look to us for guidance and protection. We must not tolerate inroads in our medical lives and practice. I beg you to continually support organized medicine, for the third-party system does not have our welfare or interests at heart.

Again I want to thank you for the honor, and I hope that I have served you well in my endeavors. Your welfare has been my sole objective at all times.

Please do not relax your efforts for self-preservation and protection. We are right now fighting for our survival.

■ REPORT OF THE PRESIDENT-ELECT

Harold J. Kief, M.D., Fond du Lac

[President-elect Kief's report appeared in the June 1967 issue of the *Wisconsin Medical Journal* at page 237.]

PROPOSAL OF THE PRESIDENT-ELECT

I do have some thoughts about courses of action that our Society might take in the year 1967, that I wish the Reference Committee of this House of Delegates would review; so, at this time, with your approval, I will read it. These are not resolutions; these are suggestions that the Reference Committee might go over.

1—It is the feeling of myself and many others that the subject of pollution in Wisconsin is of great interest to all our people. Pollution is not confined to the Conservation Department or Recreation Department alone; it can also be a medical problem.

For this reason I believe we should appoint a Commission on Pollution of our State Resources so that in the future we might be able to place intelligent medical leadership in those areas where pollution concerns the health of the people of Wisconsin.

2—Living in Wisconsin, we are all aware of the horrible death toll on our highways. No matter what our Governor or legislators have done so far, they have been unsuccessful in reducing this toll. Our Division on Safe Transportation, if you read their report (and I hope you have), has done a commendable job on this subject. Therefore, at this time I would like the House of Delegates to terminate this Division on Safe Transportation as a Division, and create it as a separate Commission. By being a Commission, I think financial support might be secured

. . . representing 53 county medical societies and 16 scientific sections.

through the CES Foundation. They would have more power as a Commission. They could enlarge the membership and engage in regional conferences and probably develop greater rapport with the legislative bodies.

3—I would like to suggest to the Reference Committee and the House that the AMA delegates be required to meet with the Council approximately one month before the annual AMA meeting and Midwinter Clinical Conference, to discuss with the State officers and Councilors activities which will be before the AMA body, and activities which the Council, officers and members of the State Medical Society wish to have our delegates promote.

Furthermore, I would suggest that it should be required that, following both the annual and midwinter meetings, the AMA delegates report to the Council, and that the Chairman, Vice Chairman and one other AMA delegate be present to give this report.

4—I would propose that a Division under the Commission on State Departments on Alcoholism and Addiction be inaugurated. I feel that this subject is broad enough and worthy of more consideration than it has been given by other committees of SMS. This is a field into which the Legislature has already voted some money, but it is a field in which medical planning and knowledge are of paramount importance. I therefore recommend that a Division on Alcoholism and Addiction be thus established.

PRESIDENT-ELECT'S COMMITTEE APPOINTMENTS

To the Committee on Cancer: There are three terms expiring. I should like to reappoint Drs. G. H. Williams of Marshfield and John K. Scott of Madison, and appoint Dr. Donald A. Jeffries of Shawano. I should like to reappoint Dr. G. A. Smiley of Delavan to serve as Chairman.

To the Committee on Grievances: Three terms expire, and I should like to reappoint Drs. O. G. Moland of Augusta and C. E. Wall of Manitowoc, and appoint Dr. Owen E. Larson of Menasha, with Dr. Elwood W. Mason of Milwaukee serving as Chairman again this year.

To the Commission on Public Policy: There are three five-year terms expiring, and I should like to reappoint all three. They are Drs. E. C. Quackenbush of Hartford; L. W. Schrank of Waupun, and T. E. Henney of Portage.

There are, in addition, six three-year terms expiring. These men are Section representatives. I should like to reappoint Dr. Karl Siebecker of Madison, from the Section on Anesthesiology; Dr. Henry Peters of Madison, from the Section on Neurology and Psychiatry, and Dr. James V. Bolger of Waukesha, from the Section on Ophthalmology.

In addition, I should like to appoint Dr. John Morrissey of Madison, from the Section on Medical Faculties; Dr. P. A. Sciarra of Sheboygan, from the Section on Otolaryngology, and Dr. J. R. Schroder of Janesville, from the Section on Pediatrics. I should like to reappoint Dr. W. T. Russell of Sun Prairie to serve as Chairman.

To the Commission on Scientific Medicine: There are two terms expiring. I should like to appoint Dr. G. J. Derus of Madison and Dr. Einar R. Daniels of Milwaukee. This Commission selects its own Chairman.

To the Commission on Hospital Relations and Medical Education: There are three terms expiring, and I should like to reappoint all three. They are: Dr. George B. Murphy, Jr., of La Crosse; Dr. Dale V. Moen of Shell Lake, and Dr. George W. Hilliard of Milwaukee, with Dr. Murphy serving again as Chairman.

To the Commission on Public Relations and Communications: Three terms expire. I should like to reappoint Dr. J. S. Devitt of Milwaukee and Dr. C. A. Olson of Baldwin. I should also like to appoint Dr. Paul E. Wainscott of Menasha. I should like to reappoint Dr. Devitt to serve as Chairman.

Vice-speaker Behnke: We will ask for approval of the committees as recommended by the President-elect, Doctor Kief.

Dr. C. J. Picard (Douglas): I so move.

[Motion seconded and carried unanimously.]

■ REPORT OF THE COUNCIL

James C. Fox, M.D., La Crosse, Chairman

[The report appears at page 460 of this issue.]

■ REPORT OF THE TREASURER

F. L. Weston, M.D., Madison

[In the absence of Doctor Weston, the report was presented by Mr. John B. White. The report appears at page 470 of this issue.]

■ REPORT OF THE SECRETARY

C. H. Crownhart, Madison

I shall happily, Mr. Vice-speaker, reassure the President and the President-elect that I take no issue with them tonight, and seldom do.

I don't think anybody in the position of employment, working for a professional association such as yours, should stand before a House of Delegates such as this and not be impressed with your devotion, your interest, and your belief in the public good.

As I sat at this table listening to Doctor Drew and Doctor Kief and the Speaker and Vice-speaker, I thought that, come next year, we might well make arrangements to record the proceedings of the House on videotape so that some of these transactions and debates and issues can be taken to every county medical society and to interested elements of the public.

Then, as I sat here, too, I thought of the Seal at my left. The Seal has been in existence since 1841. It says, "Medicina Nusquam Non Est." I hope you all know what it means, but I have a little doubt. "Medicina" stands for the art of medicine—not medicine, but the art of medicine. "Nusquam Non Est" means "nowhere is not." "The art of medicine is universal."

No legislature, no president, no Congress, can destroy an art, although it may well affect your ability to exercise that art. But the art is yours, and if you keep that in mind and hold that high you need not worry about Congress. Just worry about the care of your patients.

I do have a message to bring to you. It is not that within the province of scientific medicine because, being a lawyer, I can only listen to your debates on the subject and conclude that there are some issues in the area of scientific medicine. I can also conclude, as I told the Council yesterday and the Executive Committee the preceding evening, that there are some matters of the future which should now have your attention, and have your attention in the next months, that you and your staff not be caught short on determination of policy.

I think you all recognize that there is going to be confronting you, and confronting the public, a tremendous growth in the numbers of paramedical personnel; and there is going to be a growth in the number of those who hold themselves as a separate discipline akin to law, akin to medicine, but a separate discipline not within the borders of either.

I feel it necessary to say to you that I think the matter of privileged communication, traditionally that of the medical profession, the lawyer and the clergy, should be reviewed in depth as to the extent it should be extended to the other fields coming into being.

And as we consider that matter, I think also we should consider the standards of malpractice that may be applied to the technician and the members of "other disciplines."

You are seeing the limited licensee and the certified technician entering the hospital corridor. It is probably no real problem as yet. But who knows? What patient is able to identify personnel within the hospital staff and its responsibilities and liabilities?

And as you think of that, think of the problem attendant upon the keeping of notes. This has been your problem primarily with reference to nurses' notes. But as the psychologist enters into the hospital (and he will, one of these days), as the technician enters in, who is not strictly within the field of remedial medicine, are their notes to be part of the patient's record? And are those notes to have some relationship at least to the matter of liability?

You heard Doctor Kief tonight (and now I am on another point), and you have certainly read in your various journals, that the assistant doctor is about to come upon the scene. What is his liability? What is his privilege? What is his responsibility to you, the medical profession?

In the newspaper today, and certainly before that as well, there have been two reports on the matter of abortions, one report on action in a vacation area of the State recommending that abortion be permitted upon consent of the woman, and the National Crime Commission reports that abortion should be permitted with certain limitations.

I have not been one (either in your ranks or other ranks) to have been particularly admired for a religious belief. My own is that I believe in any religion under blue heaven. But I also think that when the courts indicate that the viable baby has legal rights, that among those rights must be the right to refuse (even though silently) to be murdered.

If there is adequate cause medically to protect the welfare of the mother or to, for other reasons, eliminate a child who would be nothing but a deformed creature, that falls perhaps with our purview of interpreting religion upon earth. I don't think it falls within the purview of either law or the medical profession to say that the destruction of a viable baby is within any form of Christian law.

When I get to that point I might bring up one somewhat related and certainly speculative, but one that should challenge the majority of physicians in the doctors' offices and the doctors' lounge, and that is artificial conception. This isn't new to you, but some aspects of it may become new. What about the baby that is conceived but the father of that child died before conception ever took place?

Finally, I come to the matter of automatic consent. In our legislative process today it is called implied consent—that the driver of the automobile, by virtue of a driver's license, either consents to an alcohol test or submits to revocation of his license. This may be necessary in the public welfare. Governor Knowles thinks it is; your Division on Safe Transportation thinks it is. But where does the end of implied consent, if it is once enacted—where does the principle end? Is the doctor going to give implied consent that periodically he will submit to re-examination or lose his license?

Is the lawyer engaged in active practice, by virtue of that fact, giving implied consent that he will submit himself to certain types of tests? I am sure it would please most of you if lawyers gave implied consent to mental tests, but I would hope that would be postponed for a while.

Is the justice of a court, by virtue of holding that office, going to give similar consent? Or may I ask you and the legislators: Should the legislator, the congressman, give implied consent to examination of his fiscal affairs at any time, or his ethical conduct at any time, or indeed as to his mental competency at any time?

These, Doctors, I think, are challenges to you primarily as citizens, with an expertise in your professional calling. I don't suggest that Wisconsin mount a soul campaign; it would take too much time and would exhaust too many people to engage in the review of these subjects. But I do suggest that Wisconsin should carry them to the national level, because if Medicina Nusquam Non Est is true in Wisconsin, it is true in the nation.

SUPPLEMENTARY NECROLOGY REPORT

Now it is my function to add to the report of the Council notification of the deaths of *Dr. Conrad Tasche* of Sheboygan and *Dr. Ralph J. M. Russell* of Wauwatosa.

INTRODUCTION OF GUEST

Vice-speaker Behnke: We are privileged to have with us a guest from Indiana, the President of the Indiana State Medical Society, Dr. Eugene F. Rifner. We are very pleased you could be with us.

OFFICERS: Dr. G. A. Behnke, vice-speaker; Dr. C. H. Crownhart, secretary; Dr. R. E. Callan, speaker; Dr. F. E. Drew, president; and Dr. H. J. Kief, president-elect.

■ REPORT OF THE WOMAN'S AUXILIARY

Mrs. David A. Hammes, Green Bay, President

It has been a very stimulating, exciting, and rewarding year to serve as President of the Woman's Auxiliary to the State Medical Society of Wisconsin. The time has rolled by much too rapidly to accomplish all I hoped to when I was installed last May; but the Auxiliary is a continuing thing, and the new officers will carry on effectively.

Our aim this year was "more members better informed." We have made great progress, but there is still work to be done. Our present membership is now 1,942 out of a potential of 4,000, with 33 organized counties, leaving 26 unorganized, and we have 2 counties without a resident physician.

Our projects are many and varied for the "better informed" part of our aim. Mrs. Yaguda, our national President, said, "An informed member will stay with us when others drop out."

Each county was urged to assess the health-related needs of her own community and then work with her medical society in fulfilling these needs.

"Meals on Wheels" proved to be a most interesting project, where members brought a hot meal once a day to the elderly and shut-ins.

"GEMS," which means Good Emergency Mother Service, trained babysitters, in other words, have been trained throughout the State.

The Block Mother Plan was instituted, where children may receive refuge in one house in the block at any time when they are in need.

A Homemaker Service was started, where if the wife was suddenly taken ill a trained person could go in and keep the home fires burning until the mother was able to come home again.

Blood banks were staffed. Glaucoma detection clinics and measles vaccination clinics were organized. Schools were supplied with information on health careers.

Horizons, a booklet listing all related health careers, was placed in each high school and in many doctors' offices, and *Today's Health* magazine was also widely circulated.

Water, bicycle, and traffic safety materials, as well as material on venereal disease, were handed out. Parents have neglected to give venereal disease information to their children. It is both a health and a moral obligation, and the incidence continues to rise.

Auxiliary members were active in legislation, opposing all legislation that would leave the physician no control over the quality of service given to his patients, and supporting the Governor's safety legislation.

I could go on and on about how as individuals and as groups Auxiliary members serve their own communities with pride, and the medical profession. We ask your continued support, both financially and morally, that we may ever continue the work that has made Wisconsin rank so high on the national level and be so respected.

I will close by reading the Ten Commandments of a Doctor's wife:

Thou shalt not know the meaning of the word "jealous."

Thou shalt never gossip.

Thou shalt run a cafeteria serving meals at all hours for your husband.

Thou shalt be like Caesar's wife—above reproach.

Thou must have self-reliance and self-control.

Thou shalt be able to think quickly and sanely in all emergencies.

Thou shalt be a diplomat—see all, hear all, say a lot, but yet say nothing.

Thou shalt learn to bear stoically and without complaint disappointments in your personal plans.

Thou shalt be a good mother and father, because doctors are often too busy to discipline their children.

Thou shalt be a good doctor, because doctors never take time to doctor themselves.

I should like to introduce Mrs. Louise Britton, who is the President-elect. I am going to "crown" her on Wednesday. Also, Leona Chesemore, our staff secretary. Louise and I could never get around the State nor do the State work without Leona.

REPORT OF THE CREDENTIALS COMMITTEE

Speaker Callan: At this time the Chair will ask for the report of the Credentials Committee. The Credentials Committee is composed of Drs. Ann Roethke, Milwaukee, Chairman; W. D. Hamlin, Mineral Point, and D. J. Twohig, Fond du Lac.

Dr. Ann Roethke (Milwaukee): The Committee on Credentials has verified the registration of 92 delegates and 13 alternate delegates entitled to vote at this session of the House of Delegates, representing 45 county medical societies and 11 sections.

Also, the Credentials Committee has been informed that the following will act as delegate for the regular delegate and alternate delegate who are unable to attend:

Clarence Zenner for Chippewa County
R. D. Heinen for Oconto County
R. E. Church for the Section on Public Health

I move that the attendance roll of delegates, alternate delegates, and specially appointed delegates, totaling 108, so compiled by the Credentials Committee, be accepted as the official roll of this session of the House.

[Motion seconded and carried unanimously.]

Speaker Callan: It is interesting to know that 108 voting delegates out of a possible 132 are here. This is a very fine representation.

REFERRAL OF REPORTS AND RESOLUTIONS TO REFERENCE COMMITTEES

So that delegates may be advised as to which reference committee will hear the various reports and resolutions submitted, this announcement is made on the subject. Where the subject matter is related, your Speaker has made every effort to refer those matters to the same reference committee.

[The reports and resolutions were referred as follows:]

Reference Committee on Reports of Officers:

Report of: President; President-elect; Secretary; No. 5—Division on Chest Diseases. No. 6—Division on Handicapped Children. No. 7—Maternal and Child Welfare. No. 8—Rehabilitation. No. 10—School Health. No. 11—Visual and Hearing Defects. No. 16—Nervous and Mental Diseases (supplementary report of Council).

Reference Committee on Reports of Standing Committees:

No. 1—Commission on Scientific Medicine. No. 2—Occupational Health. No. 3—Commission on Hospital Relations and Medical Education. No. 13—Commission on Public Policy. No. 14—Commission on Public Relations and Communications. Supplementary report on legislation (in supplementary report of Council). CES Foundation report.

Reference Committee on Resolutions:

Report No. 4—Committee on Grievances. No. 9—Division on Safe Transportation. Resolutions A through E in Handbook. Resolutions F through K in supplementary report of Council. Report No. 15—Council. Supplementary report of Council except as noted above (Report No. 16 and supplementary report on legislation).

Reference Committee on Finances:

Report No. 12—Commission on Medical Care Plans and supplementary report. WPS operations report, December 1966. Treasurer's report. Audit reports. Dues for 1968.

ELECTION OF NOMINATING COMMITTEE

[House recessed for 10 minutes to allow members of each Councilor district to select their choice for membership on the Nominating Committee.]

[After reconvening the following were nominated by their respective councilor districts:]

First District _____ R. E. Urbanek
Second District _____ W. H. Williamson
Third District _____ R. L. Beilman
Fourth District _____ W. D. Hamlin
Fifth District _____ J. F. Kovacic
Sixth District _____ J. G. Bergwall
Seventh District _____ R. A. Starr
Eighth District _____ C. E. Koepp
Ninth District _____ R. B. Larsen
Tenth District _____ C. M. Olson
Eleventh District _____ C. J. Picard
Twelfth District _____ D. J. Carlson
Thirteenth District _____ Marvin Wright

Speaker Callan: You have heard the nominations. The Chair will entertain a motion that these nominees constitute the Nominating Committee.

[Motion seconded and carried unanimously.]

TUESDAY AFTERNOON SESSION

May 9, 1967

An Extraordinary Session of the House of Delegates convened at 4:10 p.m., Drs. R. E. Callan, Speaker, and G. A. Behnke, Vice-speaker, presiding.

Speaker Callan: This Extraordinary Session of the House of Delegates of the State Medical Society of Wisconsin has as its speakers this afternoon:

T. W. Tormey, Jr., Secretary, State Board of Medical Examiners.

E. H. Jorris, State Health Officer.

Peter L. Eichman, Dean of the University of Wisconsin Medical School.

Gerald A. Kerrigan, Dean of the Marquette University School of Medicine.

John S. Hirschboeck, Coordinator, Wisconsin Regional Medical Program, Inc.

Gunnar Gundersen, Chairman, Professional Association for Civic Education.

Attorney Frank A. Ross, Jr., President, Wisconsin Association of Professions, Inc.

Miss Alice Budny, Past President, Wisconsin and American Association of Medical Assistants.

■ REPORT OF THE STATE BOARD OF MEDICAL EXAMINERS—May 1967

T. W. TORMEY, JR., M.D., Madison, Secretary

It seems, after listening to a couple of reports yesterday, that some of our thinking has been interwoven, so there may be a little repetition in what I have prepared to present to you.

We continue to be interested and active in the various facets of medical licensure.

A report on the First National Congress on Socioeconomics of Health Care presents some interesting thoughts concerning health care needs and proposed plans in the making. With the so-called shortage of physicians there is great demand for additional paramedical personnel. Over 100 such ancillary designations are employed as health workers. The Government is endeavoring to recruit up to 1,000,000 such workers in the next decade. Some of these people, of course, will want group identification in the form of certification or licensure—and this should concern us.

Recently we had an inquiry from a person about the possibility of his working as a "feldscher". This designation originated in Russia for physician assistants and as such has been widely used in Europe. The training and supervision of this group has varied widely—some even going on to specialism. In this same vein a three-eschelon plan of care is proposed—the first under the direction of the public health nurse, the second or ambulatory at the family health center, and the third at the parent institution where extensive diagnostic evaluation and in-hospital care would be given. This type of system, too, has been used in Russia for some years.

Even though not provided for in our law, the Board periodically receives inquiries about licensure for masseurs, midwives, inhalation therapists and other interests.

As you may well imagine, some of the individuals the Board sees and evaluates for medical licensure do not meet the requirements for various reasons. A number of hospitals have employed some of these people as surgical assistants, house physicians or technicians. They claim they are not practicing medicine. In view of the fact that these doctors have not obtained a license, the Board has taken the position that they should not be employed—by whatever surreptitious title—where their capabilities will be exploited as physicians even though they are entitled

to be called "doctor". Would these same hospitals employ a physician who had lost his license through legal action?

Because of the enlarging resident physician programs we are hopeful this year of obtaining legislative permission for installment payments of the license fee for those who qualify. The payments would be applied to the regular fee, payment of which would allow full activity including the moonlighting, emergency room coverage, and insurance examinations some residents now do.

Each year recently the foreign graduate Temporary Educational Permit program is filled at the present quota of 50. We would hope to see this increased to 100, and some have even suggested abandoning the quota.

Even though figures and numbers are often boring, I think the following will give you some idea of the more routine activities carried out.

In the past year we have interviewed and examined 367 physicians. Of this group 358 were M.D.s and 9 were D.O.s. Of the 118 writing candidates, 53 were graduates of foreign medical schools. We write 19 subjects. In this group of 118, 20 failed one subject and may rewrite it; 22 others failed two or more and will have the opportunity to rewrite the examination. The greatest mortality in this last group was among the foreign graduates—18 in number. A total of 104 subject failures was recorded. The subjects most often failed were anatomy, surgery, Materia Medica, and medical jurisprudence.

Of interest among our last 166 foreign applicants we find a geographic or national distribution from 42 countries. The greatest numbers are from the Philippines (48), Germany (44), Italy and Turkey (13 each) and Yugoslavia (12).

In checking over the last 283 foreign graduates licensed, 173 are still in their intended location; 33 have moved to another locality in Wisconsin; and, surprisingly, 77 have left the State or never did take up residence as they indicated they would in their applications.

Investigation of complaints by Mr. Stordock have involved such problems as improper conduct (6), practicing without registering the license (3), drug or narcotic use (8), mail fraud (1), practicing without a license (6)—(T.E.P.s and failures), quacks (4) and faith healers (1).

Actions of the Board have resulted in 2 license revocations, 2 suspensions, 2 voluntary surrenders of licenses and narcotic permits, refusal to reregister one person, re-issuance of 2 licenses, and refusal to reissue 3 others. After the usual preliminary investigation, applications for licensure were rejected in two instances, one of whom indicated he would sue the Board for $1 million.

Total registrations this past year are for 7,404 individuals:

6,340 M.D.s (4,651 in-state and 1,689 out-state.)
241 D.O.s
641 P.T.s
182 Podiatrists

■ REPORT OF THE STATE HEALTH OFFICER—May 1967

E. H. JORRIS, M.D., Madison

It is always a pleasure for me to come and speak to you, but it does seem that I am always asking you for something. I prepared a 45-minute address; but following the lead of Doctor Fox, who is from my home town, I will give you only the last 5 minutes of it.

I come before you today perhaps for the last time as Secretary of the State Board of Health. What am I talking about? Simply this: If the government reorganization bill, S.B. 55 which has now passed the Senate and has been sent over to the Assembly, is passed by the Assembly and is signed into law, the State Board of Health will go out of existence on July 1, 1967.

The State Board of Health was created by the Legislature in 1876 through the efforts of this Wisconsin State Medical Society. It has had an illustrious and proud history of public health achievement covering a span of 90 years. The Board has achieved a national reputation for excellence in many of the programs developed to improve and protect the health of Wisconsin's people. It is a history of good government, efficient and effective, with long-range planning by a professional Board and by a professional staff dedicated to their work and to the health of the people of this State.

There are seven members on the State Board of Health, appointed by the Governor with the consent of the Senate. Over the years nine of these members who have served on the Board have also been President of the State Medical Society, and I go back to the 30 years I have been with the Board. These will include: Dr. Stephen Gavin, now deceased. Dr. Gunnar Gundersen, who is in the audience. Dr. John Houghton, your Past President, and Dr. Frank Drew, your present President. Doctor Drew at this time is President of the State Board of Health.

Under this bill and government reorganization the State Board of Health is abolished and then recreated as an Advisory Council on Health, without policy-making authority or control over its budget funds or management funds. The Department of Health is given what is known in the bill as a "modified Type I transfer", and merged with the State Department of Public Welfare as a Department of Health and Social Services.

The merging, however, is not on the basis of an equal partner. The Department of Health will become a Division of Health, whereas the Department of Welfare will have five or more divisions. A new Board of Health and Social Services is created with nine members appointed by the Governor with the consent of the Senate, which will have the authority through a secretary over the budgeting, program coordination, and related management functions of the Division of Health as well as the various divisions of Social Services.

The State Health Officer will remain as the appointing authority over the employees in the Division of Health, and is administrator of the Division of Health.

The Council on Health, however, is an advisory body both to the Division of Health and to the Board of Health and Social Services. It is no more than an advisory body.

It will have veto powers. It can have veto power over the appointment of the new State Health Officer. In other words, it must approve the selection of the State Health Officer, and it must approve any transfer of functions out of the Division of Health to other Divisions of Social Services. It has certain other functions in connection with the adoption of rules and regulations by the new Board of Health and Social Services.

These seven members of the State Board of Health have taken a very strong position in opposition to the proposed merger, and believe that the best interest of the health of the people will be served if the Board of Health remains as a separate and independent policymaking Board with full control over the budgeting and expenditure of the State and Federal funds appropriated to it, and over the public health program planning.

The Council of the State Medical Society and this body have officially supported the position of the State Board of Health, and the legal staff of the State Medical Society has worked industriously to advance this position in the Senate; yet by a slim

majority of one vote, 17 to 16, the substitute amendment to the bill S. 55 was passed in the Senate and sent to the Assembly. It is now before that body and will be considered either in the latter part of this week or next week, or very shortly thereafter.

A few days ago I was shocked when one prominent State legislator informed me that he had not received one single letter, telegram or telephone call from a physician in support of the position of the State Medical Society and the State Board of Health, but that he had received dozens of letters and telegrams from both the conservationists and the veterans in support of their request to remain separate and independent.

It is not enough that the legislators are told the position of the State Medical Society by your legal representatives. They want to know the views of their own constituents, the physicians in their own communities. They want to know how you feel about it. I do not intend this afternoon to tell you what to say to them. I simply want to say this:

You have one last chance to participate in shaping the destiny and the future of public health in Wisconsin for years to come. The Assembly will vote on this bill in a few more days, or at the most weeks. Surely you have the time to call or to write or to send a telegram to your Assemblyman in the State Capitol in Madison and tell him whether you want a separate and independent State Board of Health or a newly created Board of Health and Social Services to guide the future of program planning for public health in Wisconsin.

■ REPORT OF THE DEAN, UNIVERSITY OF WISCONSIN MEDICAL SCHOOL—May 1967

PETER L. EICHMAN, M.D., Madison

It is traditional that the Dean of the Medical School address you at your annual meeting. It is a fine tradition in that it affords the opportunity to "sum up" the year. In the field of medicine there exists a significant collaborative relationship between the centers of medical education and the practicing physicians in a region. Within the framework of that relationship much has been accomplished during this year.

The Wisconsin Regional Medical Program has made progress during its planning period, and soon there will be operational programs involving the universities and the physicians in practice. Much remains to be done in planning and much more involvement between the universities and the State medical community is essential. We are privileged to have the leadership of a widely respected and well-known physician and medical educator in Doctor Hirschboeck. In view of a constructive initial year, I believe we can look forward to the next year with confidence.

The continuing medical educational programs within the State have undergone a considerable spurt in growth. Through the collaboration of the universities and the cooperation of faculty and practitioners alike, there has been an increase in university-sponsored programs of one-third over last year. In this activity the State Medical Society has played a crucial role. As impressive as this is, it is only a small beginning. The improved technology available to educators will furnish aggressive and effective solutions to distance and time, and thus bring continuing medical education to increasing numbers of interested physicians. Much credit must be given to the drive and imagination of Dr. Thomas Meyer in pushing these programs forward.

One of those activities at the University which best characterizes partnership in education is the preceptor program of our school. In this program, senior students spend three months with various practicing physicians in the State. For the first time in nearly two decades, the number of preceptors was expanded and the content of programs altered to provide the widest possible exposure of students to the varieties of roles open to the practicing physician.

Another major development this year has been the establishment of a Governor's Task Force for Medical Education which is charged, among other things, with analyzing State needs for physicians and recommending steps which might be taken to meet these needs.

The interest of the Governor in the problems of medicine is timely and important. The problems in health manpower are urgent and complicated. The education of physicians, their postgraduate training and their selection of Wisconsin as the location for their professional careers, is very important to all of us. It is to be hoped that this Task Force, with the leadership of Dr. Donald Slichter, will act as a catalytic agent in initiating important and constructive changes in the State.

I have cited these developments as examples of collaboration and mutual concern which extend beyond the University and involve other sectors of society, both private and public. They may serve as models of successful cooperation and lead to changes which will make Wisconsin a more attractive place to practice medicine and a healthier place to live.

If we can work together on the many unsolved problems, many goals which seem unattainable now will lie within our grasp. We in the universities stand ready and willing, and I am sure you do.

■ REPORT OF THE DEAN, MARQUETTE UNIVERSITY SCHOOL OF MEDICINE—May 1967

GERALD A. KERRIGAN, M.D., Milwaukee

During the past year I have had the opportunity to become better acquainted with many members of this Society and many of its officers and staff, and I have enjoyed coming to know these people.

As I have said before to some of you, I think the medical profession, which is an ancient and learned profession, is under great stress these days. I think that stress is due to the fact that we are in the midst of scientific, social and economic changes in the way in which medicine is taught and practiced. The changes which are all about us reflect the growth of scientific knowledge in recent decades.

As in other fields such as transportation and communications, the application of technical scientific knowledge to health care is leading to economic and social changes in the community. As changes in the way in which medical care is financed and delivered take place, we have urgent need as physicians to recognize what is essential in our profession and to advance our contribution as physicians to the community.

I am confident that continued close liaison between the medical schools of the State and the State Medical Society will aid us to meet the health needs of our State in the most effective way.

■ REPORT OF THE WISCONSIN REGIONAL MEDICAL PROGRAM—May 1967

JOHN S. HIRSCHBOECK, M.D., Milwaukee, Coordinator

I am happy to be able to tell you about the Wisconsin Regional Medical Program. I am actually going to give you two speeches. The first is already in galley form and will be in the next issue of the *Wisconsin Medical Journal*. I will not bother to read it but merely mention the title—*Wisconsin Regional*

Medical Program—Opportunity and Challenge. I urge all of you to read it because it will give you a feeling for the meaning of the Wisconsin Regional Medical Program as I see it and some of those with whom I am associated see it. (The article appeared in the May issue at page 223.)

The second speech is more or less an extemporaneous one which will bring you up-to-date, as it were, with developments in the Wisconsin Regional Medical Program.

Interest in this activity first came about when Congressman Henry Reuss sent a telegram to Doctor Crow, who was at that time the Acting Dean at the University of Wisconsin, and to me, still then Dean of Marquette Medical School, asking, "What are you going to do about getting one of these medical complexes in Wisconsin?"

Someone had the idea that there would be emerging a multi-million dollar building project somewhere between Milwaukee and Madison, perhaps in Watertown, and I was very much concerned when I received a phone call from a physician in Watertown wondering where this was going to be built.

I mention this to indicate that the Regional Medical Programs as they finally have emerged in Public Law 89–239 are a far cry from the original concept which existed in the De Bakey Commission report and which served as a basis for the introduction of this legislation.

The De Bakey Commission report recommended that a network of 32 medical centers be created throughout the nation to focus upon the health care activities in areas of heart disease, cancer, stroke, and other major diseases, as the first draft of the legislation stated.

This has now been changed into a different sort of program, thanks to the American Medical Association, the American Hospital Association, the American Heart Association, medical educators to a considerable extent, and many others who are interested in seeing this program take an entirely different form.

The emphasis is now entirely on programming in postgraduate education. It is not on the erection of new facilities simply to create a medical center where none existed previously.

The purposes of the Wisconsin Regional Medical Program are as follows:

1—To evolve a plan to improve service, education and research in the areas of heart disease, stroke, cancer and related diseases in the Wisconsin region. We are to evolve a plan.

2—Through this plan to narrow the gap between the rapid advances in medical science and their prompt application to the citizens of the Wisconsin region.

3—To do this through establishing cooperative arrangements between educational institutions, hospitals, health agencies, physicians, the health professions, to improve the efficiency of health services.

4—To improve the effectiveness of and expand manpower resources in the region.

In order to do this, the Wisconsin Regional Medical Program acts through a corporation which was formed by the Presidents of the two Universities with medical schools. This corporation has a Board of Directors which manages the affairs of the corporation. The Board is made up of seven and includes Doctor Drew as one of its corporate members.

The law provides for an Advisory Committee; in this case in Wisconsin this is a Committee of some 41 people representing the general public as well as the health professions. The principal representative of the State Medical Society on this Committee is Dr. George Murphy of La Crosse who, as you know, is head of the Commission on Hospital Relations and Medical Education of the State Medical Society. Doctor Murphy is also a member of the Northlands Medical Region Program, which is the Minnesota Program, and in this way acts as a liaison between both groups.

The Regional Advisory Committee according to the law has a very important role. Nothing can be moved from Wisconsin to Washington for financing or approval unless it is first cleared by this important Committee. This Committee is also to provide advice and informational input into the Program, and in this way help create it.

The Wisconsin Regional Medical Program has a staff which functions under the Board of Directors, a regional program coordinator, a position which I occupy, and three assistant coordinators—one within the University of Wisconsin Medical School, Dr. Robert Johnson; one within Marquette University School of Medicine, Avrum Organick; and the third assistant administrator who acts directly under me and acts as liaison with areas outside the two major medical school affiliated group.

In addition to the staff there is a Planning Committee made up essentially of people who have experience in the area of planning. The Chairman of this is an engineer who is head of the Industrial Engineering Section at the University of Wisconsin. I won't go into why engineering is involved in this because it would take a long time. Be that as it may, the planning of this is to go in the direction of creating a model of all of the elements which go into a good health care system for the Wisconsin region.

In order for the Planning Committee to begin its work, the Program office encouraged the solicitation of proposals for operational grants through the Wisconsin Regional Medical Program. We have received 26 such proposals at this time, and they have furnished a very fine source of information to us as to what physicians of the region are thinking in terms of what a Regional Medical Program might do.

They vary considerably in the areas of stroke, cancer, hypertension, manpower, education, that come from such disparate agencies as the Wisconsin Heart Association to a small hospital in Milwaukee. They come from both medical schools. They come from some of the large clinics in the State. So, this is evidence that there is interest in what might come out of a Wisconsin Regional Medical Program.

There is a Postgraduate Committee which is active in developing new ways of updating not only the medical profession in all of the new knowledge coming along, but also all of the other health professions.

Similarly, there is a Nursing Committee which is charged with the responsibility of trying to see what can be done about the nursing manpower shortage, as well as how nursing as a profession can bring back into active service the many nurses who are no longer practicing. A recent survey indicated that if this could be handled in a new way there might be a considerable harvest of former nurses coming back into active practice, if we can go about this in a way that might be different from past approaches.

Finally, what is the philosophy of the Wisconsin Regional Medical Program? On the basis of the way the law now stands, we believe that the Wisconsin Regional Medical Program should be under the sponsorship of a private agency, and it is a nonprofit corporation.

That it should be closely moored to the Universities, which it is through the active participation of both medical schools.

That it is an evolutionary program.

That the physicians and the faculties of the medical school and the other health professions in the region are going to create this really themselves with the help and the advice of operations research and systems engineering.

Finally, that we hope in this way to spread the

influence of the medical schools fully into the region in such a way that the care of patients can be handled at home in the area at the same level of excellence that it can be handled in the large medical centers. In other words, the end result of this should be to improve the health care of the people of the region as best it can be done within their home environment.

This is not a program to drain more patients into Milwaukee and Madison. Its goal is exactly the opposite: to provide an extension of the resources of Madison and Milwaukee and some of the larger group clinics in the State into the region in such a way that patients receive, through sophisticated communication devices, other new developments that are here with us in engineering, all of the benefits that they could receive no matter where they would be in the United States.

This is an evolutionary program. It is not one that is going to disrupt the practice of medicine; in fact, the law does not allow this. The law specifically states that there shall be nothing to interfere with the established patterns of medical practice or the administration of hospitals.

So, this is a program for improving manpower and other resources, and making available discoveries as quickly as possible for implementation by the patients in the region.

PRESENTATION OF CHECKS TO MEDICAL SCHOOLS IN WISCONSIN FROM AMA–ERF

Speaker Callan: In the absence of Doctor Blanchard, the Wisconsin Chairman for the American Medical Association Education and Research Foundation, I have the pleasant task of presenting checks to the two medical schools in our State. These checks represent contributions from physicians, their families, and friends of medicine throughout the country. More than $1 million is being distributed by the AMA–ERF to medical schools in the United States this year.

I think it is important to note that these grants are completely unrestricted. The deans may use them in any way they feel the contributions will best benefit their individual medical school. Contributors to the AMA–ERF for this program may designate a specific school to receive their grants or gifts, or they can give without designation. In the latter case the contributions are distributed equally among the 88 approved medical schools.

Will the deans please come forward?

At this time it is my privilege, acting for Doctor Blanchard, to present a check for $7,833.38 to Dean Eichman for the University of Wisconsin Medical School. This represents $5,019 in designated contributions, plus your share of undesignated gifts.

Dean Kerrigan's check for Marquette University School of Medicine is $11,983.21, of which $9,168.83 were designated contributions.

REPORT OF THE PROFESSIONAL ASSOCIATION FOR CIVIC EDUCATION—PACE—May 1967

GUNNAR GUNDERSEN, M.D., La Crosse, Chairman

As Doctor Callan indicated, I am giving you in a way a report on the stewardship of the PACE movement—Professional Association for Civic Education—during the past several months since its inception and the creation of this organization under your specific direction.

The advance of Government into traditionally private enterprise function is probably the greatest political phenomenon of our times. We Americans have always thought we had sufficient political maturity (sophistication is probably a better word) to mix government and free enterprise in such harmonious proportions that we could create the truly Great Society.

But our recipe seems to suffer from too much government. We have tried to solve every social problem with a dash of money and a double measure of bureaucracy. The result is both frustrating and challenging to every citizen, and more especially these days to every physician.

The events of 1966 and even 1965 make it very clear that politics will not keep out of medicine. From now on the merits of medical care for many of our patients will no longer be determined primarily on scientific grounds; instead, they will be deeply influenced by legislation too often aimed at assuring ballot-box blues rather than restoring the patient's health.

I am sure that every physician will do all within his power to see that his patients get the best possible care under this system. Yet it is obvious that neither the social planners nor legislators nor Congress nor even Presidents will relent in their use of this new-found political bonanza. It is time we realize that the only real check on government is at the polls.

Raymond Molley is quoted as having said (and I suppose this is a reflection of his change of attitude since the New Deal days), "Power is where the lawmakers are made, not where the laws are made."

This basic political fact was the motivating force behind your action last October when you gave a double-barreled endorsement to PACE, the Professional Association for Civic Education.

You first provided financial support to assure PACE the opportunity to conduct a long-range, continuing program of political education. This program will, among other things, demonstrate that medicine is and should be the dominant influence in appropriate health care for the people of this State.

Then, by resolution you urged every physician and every physician's wife to become a member of PACE, thus strengthening the hand of the profession in political action.

It has been my privilege to have an active part in the American Medical Political Action Committee, known as AMPAC, since its inception in 1960. I have watched state after state develop successful Political Action Committees. It was especially gratifying to me when, six months ago, you gave your blessing to PACE in our own State. Your action could not have been more timely. PACE was launched when enthusiasm was high and energy was abundant. Nationally, AMPAC was active in 146 contests for congressional seats. Candidates supported by AMPAC were successful in better than 80 per cent of the cases.

In Wisconsin the political arm of PACE was active in several campaigns, and the candidates it supported were equally successful. In the process literally hundreds of professional men and their wives learned how to put their time and money to effective use in politics.

When I began these remarks I spoke of the frustration and the challenge of our times. When the average physician becomes concerned about what his Government is doing or failing to do, he is apt to express his frustration with the question, "What can I do?" PACE and AMPAC believe that the answer to this question is in itself a challenge to the physician. Let me illustrate.

We all know that a high percentage of our over-65 patients are confused, dissatisfied and perplexed by the operation of Medicare. I might add that I am personally in that category. The insurance carriers are rightfully disgruntled at Medicare's complete disregard of proven patterns of claim processing. Even Government administrators must admit that

their high purpose has bogged down in a quagmire of paper work. I suppose a more modern term would be "this snafu," which isn't very polite.

There is not a man among you who is satisfied with Medicare; yet it is the law of the land and we have pledged ourselves as a profession to help make it work for the best interests of our patients.

Here is a magnificent opportunity for physicians to demonstrate their citizenship, and the time is ripe. The House Ways and Means Committee of the Congress is right now considering the 1967 Social Security amendments in the form of H.R. 5710. This is the first chance for major changes in Medicare and Medicaid. What have you done to inform Congressman John Byrnes of Green Bay? He is a very influential minority leader of this Committee. What have you done to inform your congressman? You might well suggest to him that both Medicare and Medicaid permit payment for services on the basis of the physician's itemized statement of charges. This one amendment would do much to unsnarl the gigantic administrative tangle in Medicare.

You might suggest that Congress be concerned about the trend toward centralization and administration of Medicare including claims and reasonable fees, matters which now operate by way of Baltimore. If this trend continues it will quickly stifle all hope of making Medicare unique among Government health programs in its ability to be responsive locally to the needs of the patient.

You could ask Congress to remove the recertification requirements for hospital and nursing home patients. They are a costly, time-consuming waste of the physician's skill, and are more likely to deprive patients of adequate care than to protect Medicare from abuse.

You could ask Congress to defer action on plans to provide Medicare benefits to disabled persons below the age of 65.

Many of these men and women already have available to them programs of health care offering broader benefits than Medicare. Here is a real challenge for citizenship. I am confident that a flood of letters with provocative ideas for improving Medicare would be met with appreciation from patients and lawmakers alike.

We in PACE do our utmost to encourage frequent thoughtful contact with those who govern at every level. We regard it as an essential part of every physician's responsibility for better government.

All of this brings me to the last phase of my discussion—a brief report on objectives for 1967 and 1968. Our primary goal in PACE in the next several months is to increase membership. We now have about 250 members out of our total physician population. By the end of 1967 we should number at least 1,000.

Some say it can't be done in an off-election year. This should not be so. If PACE is to be effective it needs members who are here today and here tomorrow. Members make it possible to carry out a continuing educational program, first informing themselves and then informing the legislators. Members are voices for better government. Members are votes to oppose quackery and promote legitimate public health measures. Members mean dollars for realistic support to those people who we may feel are deserving.

I must ask you for your help in this priority objective. I hope that before this meeting is ended there will be none among you who is not a member of PACE.

Another objective for 1967–1968 is to strengthen PACE by broadening its base among the professions. While our first task must be to demonstrate the force of physicians in PACE and AMPAC, it is axiomatic that other professions are concerned similar to ours. I am pleased to report to you that the President of the Wisconsin State Dental Society has urged dentists to emulate the medical profession in political action. As a result, PACE is now discussing with dentists the prospects of a joint endeavor. We hope we may likewise engage the interests of other professions.

Thirdly, we are undertaking a series of projects which we believe will be of service to each member of PACE and to every segment of the profession. These include educational workshops and seminars; distribution of in-depth political analyses; improved informational bulletins; new ways for the candidates of support committees and similar activities.

Finally, may I express my appreciation to this House for its support of PACE and for the many individual efforts toward better government through political education and political action. We on the PACE Board of Directors look forward to working with you in achievement of these ends. It will require our best thinking and our best effort.

If you will forgive me another quotation, I think the situation is best summarized perhaps by that most famous man of few words, Abraham Lincoln, who stated:

"The dogmas of the quiet past are inadequate to the stormy present. As our case is new, so must we think anew and act anew."

■ REPORT OF THE WISCONSIN ASSOCIATION OF PROFESSIONS—May 1967

FRANK A. ROSS, JR., Attorney, President

The Wisconsin Association of Professions is a group of nine professional organizations which have been banded together to help promote the image of the professions and to help the exchange of ideas between the professions. I might say that Dr. Gundersen's notation that PACE should be expanded into other professions is certainly one of the reasons why this Association was formed.

I can't discuss all the questions about this, but I do have one or two points that I would like to make.

No. 1: I think international professionalism is changing. I think it is important that the professions in the United States understand what is going on in the professions in other countries, and I think it is important that the professions as a whole keep track of this problem.

No. 2: The question of advertising and the image of the professional. I think this affects doctors, as you are, lawyers, as I am, and all professionals. Advertising is sometimes considered a dirty word or something that you should not talk about. Nevertheless, I think we must recognize that to keep a proper professional image we have some problems, and one of them is in advertising.

The professional image, at least in my opinion, has decreased to some extent in the last 15 or 20 years. One of the reasons I might say is the advent of the $15,000-a-year tradesman. It may not affect all doctors, but certainly if a professional person is making less than the plumber next door this tends to downgrade the professions.

Another reason (and I think this does directly affect doctors) is the era of specialization. At one time the doctor was the friendly family physician who would come out in the middle of the night to treat his patient. We all recognize that with the era of specialization the doctor cannot do this. I think some of the general public (incorrectly) feel that because of the fact that the doctor does not come out in the middle of the night, they are not receiving as good treatment. I think this is completely false, but it is certainly partly responsible for the creation of a different image in the minds of the general public.

I think joint advertising and joint speaking to high school students, to obtain the best young people in the profession, is of advantage to all professions.

The third subject that I want to discuss briefly is that of legislation. There are a number of states in which this type of group has been formed, as you people and the attorneys and a number of other professionals individually lobby for each thing and help to obtain its passage.

I, as an attorney, specifically would like to point to another area where I think the professionals should all be interested in the same goal. I venture to guess that there are some of you in this audience who possibly would be in the income bracket of $40,000 to $50,000 a year. I also venture to guess that there are some of you in the audience who do not realize that if you were killed by the negligent act of someone else, your family's recovery from that person—no matter what his assets, and presuming that you had a family of five children—would be $34,500.

I myself consider this to be a crime, but nevertheless that is the way the Wisconsin statutes read. I feel this should be of interest to the professional people, because I think this discriminates against professional people. This is one of the areas in which I think the Wisconsin Association of the Professions can and should be helpful.

REPORT OF CREDENTIALS COMMITTEE

Doctor Roethke: The Committee on Credentials has verified the registration of 76 delegates and 16 alternate delegates entitled to vote at this session of the House of Delegates, representing 42 county medical societies and 10 sections.

Also, the Credentials Committee has been informed that the following will act as delegate for the regular delegate and alternate who are unable to attend:

G. C. Hillery for Grant County.
R. D. Heinen for Oconto County.
Ruth E. Church for the Section on Public Health.

I move that the attendance roll of delegates, alternate delegates and specially appointed delegates, totaling 95, so compiled by the Credentials Committee, be accepted as the official roll of this session of the House.

[Motion seconded and carried unanimously.]

■ REPORT OF THE WISCONSIN STATE MEDICAL ASSISTANTS SOCIETY—May 1967

MISS ALICE BUDNY, Milwaukee, Past President

I am as pleased as can be to have this unparalleled opportunity to address this distinguished House of Delegates. I consider this a rare privilege, really I do, because how often can a medical assistant get her doctor to sit long enough and quietly enough to listen to her? [Laughter]

I would like to present to you today the real image of our Society, the dynamic one, capable of adjusting to the needs of the medical profession.

The Wisconsin State Medical Assistants Society has the unique advantage of being the only organization of medical assistants recognized by your State Medical Society, and presently we have 16 component chapters representing 500 members. We are also a charter affiliate of the American Association of Medical Assistants since 1956. We have 45 organized states and a membership of 13,000.

In 1962 the House of Delegates of the American Medical Association adopted a resolution encouraging all doctors to urge their girls to become members of our Society and to participate in our programs. Some doctors (and I don't say you) have questioned our motive. At this point I would like very much to lay to rest your fears concerning a union for medical assistants. An uncompromising statement in our Constitution and Bylaws rules out any unionizational efforts within our group. It is not, nor shall it ever become, a trade union or collective bargaining agency. I assure you, Doctors, that we will never advertise our problems or our unpleasantries on placards.

As the practice of medicine becomes more specialized, so does the work of the physician's assistant, and on-the-job training is no longer adequate. The prime objective of our association at all three levels—that is, county, state and national—is that of education.

A recent contribution of $5,000 by Lederle Laboratories has enabled the national organization to begin preparing a much-needed standardized course of training for approved junior colleges throughout the United States. This project is a major undertaking, but the increasing interest in this area shown by state and federal governments as well as other outside groups makes it absolutely mandatory for our association to take the lead—to set the standards for this profession. We are under the guidance of the AMA Department of Education on this project.

On a state level our Society has been instrumental in setting up medical assistant training programs in Milwaukee, Madison, Sheboygan, Kenosha, and Green Bay. In addition, seminars, workshops, leadership training programs, monthly and annual meetings, are sponsored by our Society in an effort to update our membership.

In many instances this is the only meeting that your aide has to become acquainted with the many facets of her job. We frequently call upon your colleagues to lecture to us at these meetings.

When this standardization program is implemented it will be a tremendous aid, I believe, to the medical profession in procuring qualified personnel, which I am sure all of us must admit is becoming quite a chore at times. The demand for trained help is by far greater than the supply. The need is apparent and urgent for better trained medical personnel.

I would venture to say that the medical assistant is in a strategic position, one in which she is constantly dealing with public relations, thereby affecting medicine's public image, and consequently having a tremendous impact on the success of your practice. It is important, therefore, that self-education be continued by all medical assistants.

If you, the physician, are to meet the demands of your busy practice, you must be freed as much as possible from those tasks which can be handled by an efficient, responsible and well-trained assistant. Is your assistant filling the bill as you would like her to?

Of considerable interest also is the national certification program, which is an opportunity for medical assistants to voluntarily upgrade their position. The examination is a two-day written test on the administrative and technical aspects of a medical practice. I am very happy to say that Wisconsin thus far has eight certified medical assistants. This program has been kept alive through grants from Merck, Sharp & Dohme.

We are also very enthused about a research development program. We have hopes that this particular program is going to help us determine measures to attract more women into the profession of medical assisting, that it is going to establish a criterion of desirable attributes of a medical assistant, and that it is going to establish a National Placement Service to help doctors find assistants more easily, and to help assistants find other employment.

I hope that by now it has become apparent to you, as it has to me, that our two societies' goals converge. Doctors, you can help yourselves by helping us. Give us your help. Please spread the word about

our organization. Encourage your medical assistant to avail herself of the educational benefits that we offer, and urge her to become a participating member of our Association.

Our potential membership in Wisconsin is tremendous. There are almost 4,500 doctors in Wisconsin, and yet we have only 500 interested medical assistants. This group is composed of dedicated women. This just doesn't seem right somehow. Our membership should probably be 2,000, not 500.

A modest investment on your part, in the form of prepaid membership fees of only $20 for tri-level membership, would be, I am sure, the needed bait that some girls need to join our organization. This would be a business expense to you doctors. Your dividends in turn, I am sure, would be manifold.

In exactly one month from today, on June 9, I shall be standing as Speaker of the House of Delegates of the Wisconsin State Medical Assistants Society. We are going to reevaluate our status and the progress we have made. The dates are June 9 and 10, a Friday, Saturday and Sunday, at the Park Motor Inn in Madison. Why not give your medical assistant time off to attend this meeting? I certainly shall look forward to meeting her, and I hope you will help us.

TUESDAY EVENING SESSION

May 9, 1967

The Second Session of the House of Delegates convened at 7:40 p.m., Drs. R. E. Callan and G. A. Behnke, Speaker and Vice-speaker, presiding.

REPORT OF CREDENTIALS COMMITTEE

Doctor Roethke: The Committee on Credentials has verified the registration of 61 delegates and 11 alternate delegates entitled to vote at this session of the House of Delegates, representing 36 county medical societies and 7 sections.

Also, the Credentials Committee has been informed that the following will act as delegate for the regular delegate and alternate who are unable to attend:

Thomas Jennings for Milwaukee County
G. C. Hillery for Grant County
R. D. Heinen for Oconto County

I move that the attendance roll of delegates, alternate delegates and specially appointed delegates, totaling 75, so compiled by the Credentials Committee, be accepted as the official roll of this session of the House.

[Motion seconded and carried unanimously.]

■ REPORT OF REFERENCE COMMITTEE ON REPORTS OF OFFICERS—May 1967

Vice-speaker Behnke: The first committee to report is the Reference Committee on Reports of Officers, composed of Drs. C. J. Strang, Barron, Chairman; E. D. Sorenson, Elkhorn; R. E. Urbanek, Beaver Dam; R. F. Lewis, Marshfield; and G. W. Dean, Milwaukee.

Dr. R. E. Urbanek (Beaver Dam): Your Reference Committee on Reports of Officers met in open session and considered ten items consisting of seven Division reports, plus the reports of the President, the President-elect, and the Secretary.

The Presidential Report of Doctor Drew gave evidence of a busy year in office. He has represented his profession and its State Society well, and he is to be commended for his service. His views of the future of organized medicine, as he sees it, are well taken, and your Reference Committee heartily agrees with his efforts to safeguard its welfare.

Your Reference Committee believes that Doctor Drew should receive special thanks for his stimulating articles which were carried in the *Wisconsin Medical Journal* during his term of office.

I move acceptance of this portion of the report.

[Motion seconded and carried unanimously.]

Doctor Urbanek: The next item was the report of the President-elect. Doctor Kief offers four suggested activities to be undertaken by the State Society. On the matter of a Commission to study pollution of the resources of our State, your Reference Committee recommends that such a study Commission be named by the Society.

Doctor Kief lauded the efforts of the Division on Safe Transportation but recommends that this Division be reconstituted as a Commission. Your Reference Committee recommends that the Council create Commission status for the Division on Safe Transportation.

The third suggestion is that the Wisconsin delegation to the American Medical Association meet with the Council prior to AMA meetings to discuss the various activities which should be promoted. Your Reference Committee endorses this proposal and also suggests that a minimum of three members of the delegation make a report to the Council and officers after each AMA meeting.

The fourth and final proposal of the President-elect was the creation of a Division on Alcoholism and Addiction within the Commission on State Departments. Your Reference Committee recommends that such a Division be established.

Because of its significance, your Reference Committee recommends that the report of the President-elect be brought to the attention of the entire membership.

I move the acceptance of this portion of the report.

[Motion seconded and carried unanimously.]

Doctor Urbanek: The report of the Secretary was one of great substance. He pointed out several matters in the future, such as the growth of paramedical personnel, separate disciplines, and the like. Matters such as abortion, human experimentation, and preservation of human tissues will produce responsibilities which will require the best talents of all concerned.

Your Reference Committee recommends that the Secretary's report be accepted, and the points he made regarding implied consent, as well as the topics previously referred to, will warrant marked and continued consideration by the medical profession and other disciplines.

I move acceptance of this portion of the report.

[Motion seconded and carried unanimously.]

Doctor Urbanek: The fourth item of business was the report of the Division on Chest Diseases. Your Reference Committee commends this report and congratulates the Division for the role it played in the development of the report, *Recommendations on the Use of Tuberculin Tests and Chemoprophylaxis.*

I move acceptance of this portion of the report.

[Motion seconded and carried unanimously.]

Doctor Urbanek: The next report considered by the Reference Committee was the report of the Division on Handicapped Children. Your Reference Committee recommends acceptance of the report of this Division, and also wishes to commend the Bureau for Handicapped Children of the State Department of Public Instruction, and also thanks Doctor Tenney for his continuing cooperation with the Division.

I move acceptance of this portion of the report.

[Motion seconded and carried unanimously.]

Doctor Urbanek: Your Reference Committee notes that the Division on Maternal and Child Welfare is continuing its maternal mortality survey activity. The Reference Committee shares the concern of the

REFERENCE COMMITTEE ON REPORTS OF OFFICERS: Dr. E. D. Sorenson, Dr. G. W. Dean, Dr. R. E. Urbanek, and Dr. R. F. Lewis. The chairman, Dr. C. J. Strang, was absent.

Division over lack of facilities in certain hospitals to meet obstetrical emergencies, and endorses the recommendations to study possible solutions in cooperation with the Board of Health and the Wisconsin Hospital Association. Your Reference Committee endorses the perinatal pilot study. The report of the Division emphasizes that prematurity continues to be a matter of concern.

The Reference Committee endorses the teaching programs contemplated for the year 1967–68. Your Reference Committee recommends that the maternal mortality institutes be resumed if possible, and that studies and recommendations with respect to lack of facilities, upgrading facilities, and the like, are anticipated.

I move acceptance of this portion of the report.

[Motion seconded and carried unanimously.]

Doctor Urbanek: The next item was the report on Rehabilitation. Your Reference Committee concurs in the recommendation of the Division that there be no change in the present policy, which is to provide reimbursement for psychological services only when under the supervision of, and such services are billed for, by a physician.

Your Reference Committee moves acceptance of the report in its entirety, which includes a conference under medical sponsorship to inform county societies regarding available funds for, as well as ongoing programs in, the fields of physical, speech, occupational and hearing therapy.

I move acceptance of this portion of the report.

[Motion seconded and carried unanimously.]

Doctor Urbanek: Your Reference Committee encourages the consideration of special types of physical education, as suggested by the Division on School Health, which would be available to students when, in the opinion of the attending physician, a student is not able to undertake the current courses. Your Reference Committee approves the idea of the new adaptive physical education form.

It is recommended that the report of the Division on School Health be accepted in its entirety. I so move.

[Motion seconded and carried unanimously.]

Doctor Urbanek: The next report considered was the report of the Division on Visual and Hearing Defects. Your Reference Committee recommends acceptance of this report in its entirety, and notes with favor the separation of the Division—one on Ear, Nose and Throat, and the other on Vision.

I move acceptance of this portion of the report.

[Motion seconded and carried unanimously.]

Doctor Urbanek: The final item of business was Report No. 16, submitted by the Division on Nervous and Mental Diseases. The Reference Committee recommends adoption of the report of the Division, and wishes to emphasize that all physicians should be alert to mental health problems in their respective areas and also become involved in program planning as well as program direction.

In the event the Mental Health Advisory Committee is terminated, it is believed that any agency which might be developed or designated to continue the functions contained in the original concept of the Committee, that the following be stressed:

A—Need for and importance of coordinated planning of health and welfare programs.

B—Essentiality of nongovernmental voice in programming and planning, including both medical and general citizen representation.

C—Opinion that an Interagency Committee on Health and Welfare could not perform the functions outlined in the original concepts of the Mental Health Advisory Committee.

D—Medical (SMS) support for good mental health programs and facilities.

I move acceptance of this portion of the report.

[Motion seconded and carried unanimously.]

Doctor Urbanek: I now move acceptance of this report as a whole.

[Motion seconded and carried unanimously.]

■ REPORT OF REFERENCE COMMITTEE ON REPORTS OF STANDING COMMITTEES—May 1967

Vice-speaker Behnke: The next reference committee to report is the Reference Committee on Reports of Standing Committees. Its Chairman is Dr. G. W. Hilliard of Milwaukee. Other members are Drs. W. F. Henken, Racine; C. E. Koepp, Marinette; W. E. Myers, Fond du Lac, and J. H. Morledge, Madison.

Dr. G. W. Hilliard (Milwaukee): Your Reference Committee on Reports of Standing Committees met in open session this morning and heard testimony on Report No. 1 submitted by the Commission on Scientific Medicine. The Reference Committee commends the Commission for its programming for the 1967 Annual Meeting and encourages the Commission to continue its efforts to set up a series of prematurity institutes. In addition, your Reference Committee would like to emphasize the availability of the Speakers Service provided by the Commission, and encourages county societies to continue supporting this Service.

I move acceptance of this portion of the report.

[Motion seconded and carried unanimously.]

Doctor Hilliard: Your Reference Committee also considered the report of the Committee on Occupational Health, and recommends that the Committee publicize in the *Wisconsin Medical Journal the* availability and the nature of the contents of the Occupational Health Guide.

In addition, your Reference Committee acknowledges that the Committee has taken initial steps with the Wisconsin State Board of Health, the Wisconsin Canners Association and the Wisconsin Committee on Migrant Labor to alleviate the health problems of the migrant laborer and recommends that this effort be continued and that special efforts be directed toward developing facilities throughout the State which are equal to those developed in the major work areas of Dodge, Door, Marquette, and Waushara Counties.

I move acceptance of this portion of the report.

[Motion seconded and carried unanimously.]

Doctor Hilliard: The report of the Commission on Public Relations and Communications outlines a potential weekly television program, "Doctors at

Work," and the Reference Committee recommends that the Commission continue its attempts to obtain sponsorship for this program.

In addition, the Commission, in its report to the House of Delegates, recommended a change in the Bylaws of the Society, Chapter VII, Sections 1 and 3, in order to change its name to Commission on Health Information. Your Reference Committee recommends to the House of Delegates that it accept this proposed change which will provide a more descriptive title for the programs under the direction of this Commission.

I move acceptance of this portion of the report.

[Motion seconded and carried unanimously.]

Doctor Hilliard: The Reference Committee also heard testimony from the Chairman of the Commission on Hospital Relations and Medical Education, and concurs with the Commission's recommendation that the House go on record encouraging nurses presently not active in the profession to take refresher courses available at various institutions and to return to the profession of nursing on some basis.

The Reference Committee also wishes to call to the attention of the House the importance of emergency medical care and the standards for emergency care which will be made mandatory under the new Highway Safety Acts. It is the recommendation of your Reference Committee that the Commission on Hospital Relations and Medical Education and the Division on Safe Transportation review the areas in which standards must be developed, and report guidelines for implementation to the House at its next session.

I move acceptance of this portion of the report.

[Motion seconded and carried unanimously.]

Doctor Hilliard: The Reference Committee next reviewed the report of the Commission on Public Policy and commends its reading to all members of the House of Delegates in order that they may be aware of current pending legislation and the positions previously adopted by the Society on such legislation.

The Reference Committee also recommends that the House go on record as opposing Assembly Bill 458 which would provide that an osteopath shall not be denied staff privileges solely because he is an osteopath. This bill could shift the burden of explanation from the applicant to the hospital and the medical staff which has the duty to pass on credentials.

I move acceptance of this portion of the report.

[Motion seconded and carried unanimously.]

Doctor Hilliard: Your Reference Committee also considered the Supplementary Report on Legislation which was forwarded to the House of Delegates with the Supplementary Report of the Council. Your Reference Committee recommends that the Society continue its previously adopted policy which is aimed at assuring that in any reorganization of State government, the State Board of Health will retain essential autonomy so as to best serve the health interests of the entire public.

Your Reference Committee also recommends that the House reaffirm the position of the Commission on Public Policy that the Wisconsin Diagnostic Center should not be closed until the medical profession of the State has had an opportunity to make a more intensive study of the proposed changes in this service which has greatly benefited the citizens of Wisconsin.

The Reference Committee notes that three bills dealing with abortion have been introduced into the Wisconsin Legislature, and recommends that the Council continue to study the situation as it exists within the State, and coordinate its deliberations with those being done on a national level by the American Medical Association.

REFERENCE COMMITTEE ON REPORTS OF STANDING COMMITTEES: Dr. C. E. Koepp, Dr. G. W. Hilliard (chairman), Dr. W. F. Henken, and Dr. W. E. Myers. Dr. J. H. Morledge was absent.

In the area of health insurance legislation, the Reference Committee recommends that the House oppose any proposal which would put WPS and all other prepayment sickness care plans under the same type of regulation that the commercial companies face. These proposals would throttle the experimental approach which has been beneficial to the health interests of the public.

I move acceptance of this portion of the report.

[Motion seconded and carried unanimously.]

Doctor Hilliard: Your Reference Committee also reviewed the Informational Report of the Executive Committee of the Board of Trustees of the Charitable, Educational and Scientific Foundation, and commends the Foundation for its successful programs and projects which have greatly aided and encouraged both the art and science of medicine.

I move acceptance of the Informational Report of the Foundation.

[Motion seconded and carried unanimously.]

Doctor Hilliard: I now move adoption of the report as a whole.

[Motion seconded and carried unanimously.]

■ REPORT OF REFERENCE COMMITTEE ON RESOLUTIONS AND AMENDMENTS TO THE CONSTITUTION AND BYLAWS

Speaker Callan: Next we will hear from the Reference Committee on Resolutions and Amendments to the Constitution and Bylaws. Members of the Committee are: Drs. H. M. Suckle, Madison, Chairman; F. E. Gehin, Stevens Point; P. G. LaBissoniere of Milwaukee; C. J. Picard, Superior, and E. P. Rohde, Galesville.

Dr. H. M. Suckle (Madison): Your Reference Committee considered report No. 4 of the Committee on Grievances which proposes a complete revision of Chapter VII, Section 5 of the Bylaws. Your Reference Committee recommends repeal of the present wording of this Section and approval of the language proposed by the Committee on Grievances through the first three paragraphs.

Your Reference Committee recommends substitution of the following final paragraph:

> "Consistent with the special purposes of this Committee, all Committee records and files pertaining to such matters shall be treated as confidential, shall not be open to inspection by other persons, shall not be released for any purpose, and shall not be subject to subpoena."

Your Reference Committee further suggests that consideration be given to a more appropriate name for the Committee on Grievances to reflect its functions of arbitration and adjudication.

I move acceptance of this portion of the report.

[Motion duly seconded.]

REFERENCE COMMITTEE ON RESOLUTIONS AND AMENDMENTS TO THE CONSTITUTION AND BYLAWS: Dr. E. P. Rohde, Dr. F. E. Gehin, Miss Joan Pyre (committee secretary), Dr. H. M. Suckle (chairman), Dr. C. J. Picard, and Dr. P. G. LaBissoniere. Dr. J. M. Sullivan is shown in the lower center.

Dr. V. M. Griffin (Juneau): It is not possible to resist the subpoena unless you make some provision for destruction of the records. I think it would be better to destroy the records rather than resist their subpoena.

Doctor Suckle: Doctor Griffin, this paragraph was put in at the suggestion of the legal counsel of the State Medical Society. We are fully cognizant of the fact that everything can be subpoenaed. However, this paragraph is used by the State Bar Association in indicating the fact that this information is confidential. As our attorneys pointed out, although everything is subject to subpoena the courts have thus far respected this confidential information and have not admitted it into evidence in a case in which this material may be used.

We felt that the confidential nature should be spelled out in our Bylaws so that any judge requesting this information or approving subpoena of this information would then be called upon to rule concerning its admissibility.

Dr. S. E. Zawodny (Milwaukee): Where would this substitution occur?

Doctor Suckle: The recommendation is that we approve the first three paragraphs, and instead of the last paragraph we would substitute this new paragraph.

Doctor Zawodny: Are you speaking of Section 5 of the Handbook?

Doctor Suckle: No. The report says, "Your Reference Committee considered report No. 4 of the Committee on Grievances." Do you have that report?

Doctor Zawodny: I see. Thank you very much.

[Motion carried unanimously.]

Doctor Suckle: Your Reference Committee next reviewed report No. 9 of the Division on Safe Transportation, and recommends acceptance and commendation of the report. Your Reference Committee appreciates the work of the Committee and its additional responsibilities, but feels that, rather than add to the complexity of committees, the Division should be enlarged if necessary to consider boat traffic and other modes of transportation.

Your Reference Committee further recognizes that although physician liability in the administration of chemical tests for intoxication is closely tied to the implied consent proposal which is now in the Legislature, it is hoped that a finalized opinion on this matter will be forthcoming soon and will be circulated to the membership of the State Medical Society, preferably by mail.

I move acceptance of this portion of the report.

[Motion seconded and carried unanimously.]

Doctor Suckle: Your Reference Committee next considered Resolution A introduced by the Shawano County Medical Society, and recommends its adoption with substitution of the word "adequate" for the words "realistic minimal" so that the resolution would read:

> "*Resolved,* That the Division on Safe Transportation of the Commission on State Departments be requested to promulgate *adequate* physical standards to be applied in the certification of school bus drivers, and their adoption by the proper State regulatory authorities be advised."

I so move.

[Motion seconded and carried unanimously.]

Doctor Suckle: Your Reference Committee considered Resolution B introduced by the Section on Urology, and reports that inasmuch as the Attorney General has been asked to restudy his position during the past year, and it is reported that such study is in progress although not finalized, and the State Board of Medical Examiners has again requested the announcement of a new opinion, it is believed preferable to again defer action on this resolution.

I so move.

[Motion seconded.]

Dr. J. G. Bergwall (Outagamie): When is it anticipated that the Attorney General will come out with an opinion?

Doctor Suckle: I think the only thing that governs the Attorney General in his actions is his desire to give an opinion. I do not know of anything that can force him to do so, and obviously our legal counsel have made a request to the Attorney General's office. The State Board of Medical Examiners has made requests, and the only answer we have had is that they have it under study.

Doctor Bergwall: Touche!

[Motion carried unanimously.]

Doctor Suckle: Your Reference Committee finds itself in full accord with the expressed intention of Resolution C introduced by the Dodge County Medical Society, but believes that there is a practical mode of implementation provided through the acceptance of the recommendations which are a part of the Special Report on Osteopathy forwarded by the Council in its supplementary report.

I move acceptance of this portion of the report.

[Motion seconded and carried unanimously.]

Doctor Suckle: Your Reference Committee has carefully considered Resolution D but feels it is unnecessary and possibly unwise to recommend specific legislation at this time, inasmuch as physicians

are ordinarily without legal liability when they serve on hospital staff committees and conduct their duties in good faith. It therefore recommends that the resolution not be adopted.

I so move.

[Motion seconded.]

Dr. W. H. Williamson (Racine): We proposed the resolution, as you know. Since we have Mr. Murphy here, I wonder if we could have a legal interpretation of the word "ordinarily."

Doctor Suckle: We would be delighted to have Mr. Murphy speak. I might say that Mr. Murphy was at the meeting of this Reference Committee when we considered this item, and it was with his approval that the report was so worded. If it is agreeable with the Chair I would be delighted to have Mr. Murphy speak.

Speaker Callan: Do you request that Mr. Murphy address the House?

Doctor Williamson: Yes. I say this because the AMA legal representatives could not possibly come up with an explanation nor interpretation of whether there would be legal immunity for a committee of this nature. If they can't, I wonder how we can.

Speaker Callan: Mr. Murphy is recognized.

Mr. Robert B. Murphy: This is a difficult question to be asked, but I do think it is worth asking. The general rule in the United States has been that where hospital committees (and this is a hospital committee), where it be of the audit variety, the tissue variety or the old-time utilization committee, conducts its work with ordinary due care and in good faith, it is insulated against liability.

On the basis that the new Statutory Utilization Committee imposed on a mandatory basis by the Medicare Law of 1965 is in essence an extension of the Utilization Committee already known in many of the country's hospitals, it was believed that it did not offer anything essentially different from what was already established in one type of committee structure or another in hospitals.

Since 1961 the conference companies writing professional liability insurance in this country have put into the wording of their policies—and so far as we can determine into all policies written certainly since that date—wording that the liability growing out of the functioning of committees related to hospital operations. A number of those companies have been contacted by Mr. Kluwin or by others for you, and several of them have asked, "What are you asking us that for? We have been covering this kind of liability for some years."

Whereas tissue and audit committees generally within a hospital and the old-time Utilization Committee were on a voluntary basis insofar as the law was concerned, and had no recognition in the law, the new type of Utilization Committee is a mandate of a Federal statute, and we think that all the protection which flowed from the earlier type of statute reasonably is available in the mandatory statute, and that there is certainly no lesser standing but, if anything, a greater standing attaching to the operation of the new type of Utilization Committee under the statute.

That is our reasoning, boiled down. We are aware that there is uncertainty. We are aware that we can't prove that we are right at this moment, because there have been no reported cases. We have asked the AMA and others, and there are no reported cases. There hasn't been that time as yet.

There are also certain risks inherent in asking for legislative relief, and you court further the very real risk, if you try to get such a bill in and fail, you again risk the argument later in a court procedure, "The Legislature could not have intended to protect the medical profession because it refused to enact a statute which had that as its end."

So, we thought it preferable to rely on the situation as we understand it and as we think we correctly interpret it.

Dr. William J. Madden (Racine): I wonder if the Reference Committee knows that the House of Delegates of the AMA, at its Las Vegas meeting of the AMA, recommended this very proposal and recommended that all state societies push this through. It was passed by the House of Delegates of the AMA.

Doctor Williamson: The mandate also applies, as I know it, to Medicare, and also not necessarily to utilization committees as they apply to other admissions that do not apply under Medicare; isn't that true?

Mr. Murphy: That is right.

Doctor Williamson: Most of these committees were formed long before Medicare became law. We are talking about possibly two different things.

Speaker Callan: Is there further discussion? The motion has been made and seconded that Resolution D be not adopted. Those in favor, say "aye"; those opposed, "no". Will those opposed please stand. I count 12. Resolution D is not adopted.

Doctor Madden: How about those in favor?

Speaker Callan: Will those in favor please stand. I guess we don't have to have a count. Continue, Doctor Suckle.

Doctor Suckle: Your Reference Committee considered together Resolutions E and F relating to Title XVIII of the Social Security Act, and recommends acceptance of both resolutions. Your Reference Committee feels, however, that safeguards should be taken for payment of the individual physician in a form that is acceptable to him after more experience is gained under the program.

I move acceptance of this portion of the report.

[Motion seconded.]

Voice: What does it mean?

Speaker Callan: Doctor Suckle, will you please elaborate?

Doctor Suckle: Yes. First of all, there is an amendment before the Congress that has been proposed by Representative Zablocki of Milwaukee concerning payment of the physician, and without necessarily having the assignment or any specific billing.

In the discussion that came before our Reference Committee it was found that approximately 55 per cent of the physicians (essentially it is a 50:50 percentage) have their assignments on record, and 50 per cent will require that the patient pay his bill directly.

With this proposed change in legislation it was the Reference Committee's feeling that there should be some leeway so that the individual physician will be paid and the Government or the paying agent should see that he is paid. Whether he wishes to be paid directly or indirectly, at least he should have the choice.

Dr. David J. Sievers (Green Lake–Waushara): Our County Society was quite opposed to that. The idea was to pay the patient. Our feeling was that in all cases the payment would be made by the Government and the patient would pay the doctor. In that proposal it was pointed out that in this way the patient had a chance to bargain with the doctor if the patient feels the fee is too high. Another thing: It would be like insurance companies paying the patient directly. The patient gets the money and the doctor doesn't get paid at all.

Doctor Suckle: That is exactly why we put in this last sentence—"that safeguards should be taken for payment of the individual physician in a form that is acceptable to him after more experience is gained under the program."

In other words, although we would recommend a change in the regulations of the Social Security Act, we feel that the physician should have the choice as

to whether he is paid directly, as some physicians wish, or whether they wish the patient to pay him and receive payment from the Government.

I realize and the Reference Committee realizes that this inequity occurs, but again 50 per cent of the Society is on one side of the fence and 50 per cent is on the other. We feel it should be up to the individual physician to determine how he should be paid.

Dr. E. L. Bernhart (Milwaukee): I understand that the Council the other day recommended a resolution to the AMA delegates, of which I am one, to commend our Representative Zablocki for his feeling about this situation to relieve some of the patient situation. I do think—and I talked with Doctor Suckle this noon—that I feel the AMA has reiterated the fact that we should not go for assignment but we should deal directly with the patient.

If the Zablocki resolution to Congress is accepted, the patient will be paid directly and we will be having sewing machines and televisions and radios instead of money in our hands.

Speaker Callan: I think you mean the patient will be having those things.

Doctor Bernhart: That's right.

Speaker Callan: Is there further discussion?

[Motion carried unanimously.]

Doctor Suckle: Your Reference Committee believes that Resolution G, by the Council, on a Beaumont commemorative stamp is eminently laudable, and recommends its adoption.

I so move.

[Motion seconded and carried unanimously.]

Doctor Suckle: Your Reference Committee recommends adoption of the three resolutions introduced by the Council at the request of the Wisconsin delegation to the American Medical Association, namely, Resolution H relating to S. 260, 90th Congress, by Senator Hart, and similar legislation; Resolution I, relating to the disability insurance program of the AMA; and Resolution J, relating to the retirement of Mr. George B. Larson, a former employee of this Society.

I so move.

Doctor Bernhart: May I ask what happened to the Zablocki resolution? There were four resolutions passed by the Council transferred to the delegates to the AMA. What happened to them, Doctor Suckle?

Doctor Suckle: Just before this, Doctor Bernhart, in the middle of page 3, the third paragraph says, "Your Reference Committee considered together Resolutions E and F relating to Title XVIII of the Social Security Act." Resolution F, as you will recall, relates to the Zablocki resolution.

Doctor Bernhart: Then you are not considering the Zablocki resolution with your proposal now?

Doctor Suckle: No. That was passed just a moment ago.

Doctor Bernhart: With your reservation?

Doctor Suckle: That is correct.

Speaker Callan: Is there objection to considering Resolutions H, I and J as one package? Hearing none, is there a second to the motion to adopt Resolutions H, I and J?

[Motion seconded, and carried unanimously.]

Doctor Suckle: Your Reference Committee heartily endorses Resolution K by the Commission on Scientific Medicine and the Council, and recommends its adoption by the House of Delegates.

I so move.

[Motion seconded, and carried unanimously.]

Doctor Suckle: Your Reference Committee reviewed the series of resolutions submitted by the Council and adopted earlier this year by the Joint Committee on Health Problems in Education of the National Education Association and the American Medical Association.

It recommends their acceptance and referral to the Division on School Health of the Commission on State Departments with the suggestion that efforts be made to avoid overlapping and duplication in studies and reports related to these resolutions.

I so move.

[Motion seconded, and carried unanimously.]

Doctor Suckle: Finally your Reference Committee reviewed Report No. 15 by the Council and portions of its supplementary report referred to this Reference Committee not earlier referred to in this report.

Your Reference Committee recommends acceptance of these reports, and specifically recommends adoption of the addition of a Reference Committee on Finances to Chapter III, Section 4 of the Bylaws.

I move acceptance of this portion of the report.

Speaker Callan: The Bylaw specifically recommended is to add a Finance Committee to the permanent reference committees of the House of Delegates.

[Motion seconded, and carried unanimously.]

Doctor Suckle: I now move adoption of the report as a whole.

[Motion seconded.]

Doctor Bernhart: Again I would like to ask the House to review its feelings about Resolutions E and F regarding Title XVIII of the Social Security Act. I understand the feelings of Congressman Zablocki and the matter of his constituents about Medicare payments, but I still feel that if this House passes this resolution with this reservation it may not be too politic to not accept this as written. I would like to hear expressions from others about this.

I think the way we have been doing this, with the recommendation of the AMA for direct payment by patients to physicians and let the Social Security Act pay these people, let them implement their procedure a little more rapidly. Then we won't have any cry. I still feel that if we approve this particular thing, even with our reservation, we have to be a little politic. Zablocki has been a good friend of ours, although I am not of his political faith. I think we should consider this a little more.

Speaker Callan: Do you move to reconsider the action on Resolution F?

Doctor Bernhart: E and F; right.

Speaker Callan: Resolution E does not pertain to Mr. Zablocki.

Doctor Bernhart: It is Resolution F.

Speaker Callan: There is a motion to reconsider the House's action on Resolution F. Is there a second?

Doctor Bergwall: I second it.

Voice: I suggest you read the resolution so we will be better apprised of its contents.

Speaker Callan: The Chairman of the Reference Committee will read Resolution F for clarification.

Doctor Suckle: This was introduced by The Medical Society of Milwaukee County.

"WHEREAS, the medical profession believes that the freedom to bill patients directly under Part B of the Social Security Act, commonly called Medicare, is in the best interest of the public and physicians, and

"WHEREAS, the right to bill patients directly under Medicare is a bulwark against government interference in the practice of medicine by restricting the physician's right to treat his patient according to his professional judgment, and

"WHEREAS, the requirement that a paid statement must be submitted by the Medicare enrollee to obtain his benefits has often resulted in financial hardship to the patient, and

"WHEREAS, the Honorable Clement J. Zablocki, Representative from Wisconsin, has recognized the inequities of this requirement in introducing H.R.

6561 to amend Title XVIII of the Social Security Act to permit an individual to be paid for charges by a physician under the supplementary benefits program prior to the individual's own payment for the charges involved, and

"WHEREAS, this amendment will reaffirm the physician–patient relationship and result in faster, more efficient operation of Medicare by correcting one of the deficiencies of the program; therefore, be it

"*Resolved:* That the State Medical Society of Wisconsin commend Congressman Zablocki for his efforts in introducing this bill to correct the deficiencies in Title XVIII of the Social Security Act; and be it further

"*Resolved:* That the State Medical Society of Wisconsin recommend full support of H.R. 6561 by the American Medical Association."

Speaker Callan: Is there further discussion of the motion to reconsider Resolution F?

Doctor Madden: Will you tell us what you have against it?

Speaker Callan: You are a little premature. The motion is to reconsider.

Doctor Madden: It has already been passed. Why should we reconsider, unless we know why Doctor Bernhart wants it reconsidered?

Speaker Callan: It is quite evident. The motion to reconsider is seconded.

Doctor Zawodny: Chairman Suckle made the statement that 50 per cent of the doctors were for it and 50 per cent were against it. I tried to figure out where the "50 per cent" came from, and the motion was passed prior to that time. That is why I would like reconsideration. If it is a fact that 50 per cent of the doctors accept assignment and 50 per cent of the doctors accept payment, that is another thing. I want to know what this 50:50 business is.

Speaker Callan: There is a motion to reconsider. Are you ready for the question?

Doctor Bernhart: I am not debating the motion to reconsider. I would like to answer Doctor Madden. I oppose this particular thing as presented. I feel that the AMA and its philosophy—

Speaker Callan: You are out of order, Doctor.

All those in favor of reconsidering Resolution F, signify by saying "aye"; those opposed, "no". Will the "ayes" please stand. Will the "noes" please stand. The motion to reconsider has won. Resolution F is now open for discussion. The vote was 52 to 49.

Doctor Bernhart, would you like to lead the discussion?

Doctor Madden: A point of order. Doesn't it take a two-thirds majority to reconsider a motion that has already been passed?

Speaker Callan: It requires a majority vote.

Doctor Bernhart: Being from Milwaukee and being a delegate to the AMA, I was at the caucus when Milwaukee passed this resolution. I like our Representative Zablocki, and I think he is doing something well for his constituents. But I don't know whether he has been doing well for the doctors.

The AMA, in their philosophy in the administration of Medicare, has advised all physicians not to accept assignments but to deal directly with the patient, and let the patient handle the receipts and pay his $50 deductible and send it to the Administration for payment. Zablocki is disturbed because some of his constituents are complaining about the slow implementation of payments that come out of the IBM and the Baltimore deal. I think we should protect ourselves—the medical group.

I would like to continue doing as I am doing. We can commend Congressman Zablocki for his loyalty to his constituents, but he has a loyalty to some of the medical profession in this area.

Dr. S. W. Hollenbeck (Milwaukee): As a Councilor I would like to say a few words. I went to a meeting of the County Medical Society one night, and Blue Cross was there in force. I will never forget the words stated by Mr. Suycott. He said, "Labor is on our backs. The public is on our backs. You fellows can make it easy for everyone if you will accept an assignment."

Doctor Zawodny: I asked a question in reconsideration of this proposal and the 50:50 business and I didn't get an answer. I wonder whether you are dealing with insurance companies or what. Once you accept an assignment, a doctor is then placed as a doctor accepting assignments. If he accepts one assignment but does not accept 99 others, he is still considered as a doctor who accepts assignments. The fact that I accept one assignment does not put me in that category.

If the Chairman was using this as 50 per cent of the doctors being for assignment and 50 per cent being against, if I accept one assignment I would be in the category of accepting assignments even though I did not accept the majority. I would like to have that straightened out.

Doctor Suckle: At the Reference Committee meeting it was the statistics of approximately 55 per cent or 50 per cent accepting assignments and 50 per cent not using assignments, from the experience of the WPS.

Doctor Zawodny: How do they get their 50 per cent? If I accept one assignment am I in the 50 per cent that accepts assignments even though I accept only one per cent of the cases?

Doctor Suckle: I don't know how that figure was determined. I would presume—well, we have the expert here, Doctor Dessloch.

Dr. E. M. Dessloch (Crawford): It is arrived at by the number of cases that come in per day, and not on the basis of having a doctor assign once. You have to assign or not assign on each individual case. It varies from time to time, and in the beginning of this calendar year when the deductible was not enforced it dropped to about 34 per cent; but now it is back up to around 50 per cent. Actually, it is 53 per cent.

Speaker Callan: Would anyone like to speak for the other side?

Doctor Bernhart: May I ask the Chair for a show of hands of how many doctors in our delegation accept assignments.

Speaker Callan: The Chair does not feel that is relevant.

Doctor Griffin: I am against the income tax and I accept it. If you want any money you had better accept assignment. We sent in literally hundreds from our group and we got no money; they all came back. We accepted assignment and we started getting some money. That is the gist of it as far as I am concerned.

Dr. William Henken (Racine): Since this seems to be relatively a 50:50 deal, what is the objection to having both the patient's name and the doctor's name on the check?

Speaker Callan: Gentlemen, I think we are getting into technicalities. We have the Reference Committee report recommending acceptance of Resolution F, feeling, however, that safeguards should be taken for payment of the individual physician in a form that is acceptable to him after more experience is gained in the program. That is the question before the House. Is there further discussion?

Doctor Bernhart: I mentioned before that I approve of what Congressman Zablocki said in his report and proposition about his constituents, but how can we relate our Reference Committee's report to him and then accept this report entirely if there is a 52 per cent vote for reconsideration? We will go along with the vote.

Speaker Callan: The question is on the acceptance of the recommendation of the Reference Committee, that Resolution F be accepted with the additional safeguard that safeguards should be taken for payment of the individual physician in a form that is acceptable to him after more experience is gained under the program.

Are you ready for the question? All those in favor of the Reference Committee's recommendation, say "aye"; those opposed, "no." The "ayes" have it. Resolution F is accepted.

Doctor Suckle: I am sorry that Doctor Bernhart had to step out, but I would like now to move adoption of the report of the Reference Committee as a whole.

[Motion seconded and carried, with one dissent.]

INTRODUCTION OF HONORED GUESTS

Speaker Callan: At this time it is a pleasure to introduce our honored guests. I am told we have with us Dr. George F. Lull, Executive Administrator of the Illinois Medical Society.

Dr. L. O. Simenstad (Polk): I would like to introduce Dr. Charles G. Sheppard, President of the Minnesota State Medical Association.

Speaker Callan: We also have the good fortune to have with us Dr. Arthur F. Goodyear, President of the Illinois State Medical Society.

Dr. C. Allen Payne, President of the Michigan State Medical Society.

Dr. Eugene F. Rifner, President of the Indiana State Medical Society.

PRESENTATION OF PLAQUES TO AMA VOLUNTEER PHYSICIANS FOR VIETNAM

Speaker Callan: At this time I would like to call on Doctor Simenstad, a member of the Board of Trustees of the American Medical Association, who will present plaques to the following for service with AMA Volunteer Physicians for Vietnam:

Thomas P. Chisholm, M.D., Arcadia
Victor S. Falk, Jr., M.D., Edgerton
William B. Gallagher, M.D., La Crosse
Samuel B. Harper, M.D., Madison
R. M. Nesemann, M.D., Kewaunee
Joseph Springer, M.D., Durand

Doctor Simenstad: Last year I had the honor to present an AMA citation to two Wisconsin physicians for their work in Vietnam. These fine doctors had made the trip several years ago. Late last summer the American Medical Association took over a program from the U. S. State Department under which it seeks volunteers among our ranks to serve in civilian hospitals in South Vietnam, as long as our help is needed.

Since last summer no less than seven Wisconsin physicians have taken part in this program. Each has spent 60 days in one or more of thirteen civilian hospitals in Vietnam. They worked long hours under sometimes appalling conditions. They slept with rifles beside their bed, and they seldom ventured out after curfew.

Their patients were the civilian victims of the war and of the ills and accidents of life in a nation of 15 million civilians and 350 civilian physicians.

For their services, these volunteers received travel expenses and a $10 daily living allowance.

Needless to say, to the people of Vietnam these men, who worked harder than they have ever worked to see the greatest number of patients in a day—these physicians proved better spokesmen for our country than many of the most articulate ambassadors.

So, in helping our fellow men, these Wisconsin physicians did you and me a favor. They demonstrated the finest in medicine and the finest in Americanism, and they have made us proud to be their colleagues.

Now it is my pleasure, as a member of the Board of Trustees of the American Medical Association and a loyal Wisconsinite, to present AMA citations to the following. All but one of the seven are here.

[Physicians came forward and were presented to the House.]

The seventh man, Dr. Charles Hopkins of Madison, cannot be here because he was committed to give a talk this evening at Madison. However, Doctor Hopkins can take consolation in the knowledge that while his six friends can only stand here and accept their awards, he can be spinning war stories for his audience, the Madison District Nurses Association.

Each of these plaques is the same, of course. They are presented by the American Medical Association "in recognition of the meritorious service he performed for the medical profession, the United States Government and the people of South Vietnam by treating the ill and injured during his medical mission under the AMA's Volunteer Physicians for Vietnam", and they are signed by Dr. Charles Hudson, President of the AMA.

Gentlemen, I am happy to present you your plaques with our congratulations.

[The House arose and applauded as the above-named physicians accepted their plaques.]

Doctor Simenstad [continuing]: If any of you others want to go to Saigon, I can arrange it for you. The AMA runs a university there, and we have been having quite a time. The State Department pays the AMA for doing this, and we get volunteers for the university. Then they have this other program whereby they take care of civilians. It is rather interesting, although they tell me it is a little hectic.

I was around the world a while ago but I didn't stop there because I heard too many rumors that they were having problems. If any of you are interested, get in touch with me or the AMA and we will be glad to take you.

■ REPORT OF REFERENCE COMMITTEE ON FINANCES

Vice-Speaker Behnke: The last reference committee is that on Finances. Members are Drs. A. H. Stahmer, Wausau, Chairman; L. R. Weinshel, Milwaukee; R. L. Beilman, Madison; J. W. McRoberts, Sheboygan; and F. D. Cook, Green Bay.

Dr. A. H. Stahmer (Wausau): Your Reference Committee on Finances examined in detail the report of the Commission on Medical Care Plans and its supplementary report. It is noted there have been "teething" problems in connection with the implementation of the Government programs (Medicare and Title XIX), but there are assurances from physicians representing the Commission and the staff that these problems are being resolved. A few exceptions are being given special treatment and will require handling on an individual basis.

The supplementary report of the Commission was in answer to 1966 House action calling for more activity in the sale of diagnostic and other medical outpatient benefits by health insurance carriers. This morning your Reference Committee heard from a representative of the Health Insurance Council who stated that affirmative action is being taken, that many companies provide these benefits, and that promotion of the sale of these benefits will be continued.

Your Reference Committee recommends approval and acceptance of the two reports of the Commission on Medical Care Plans.

I so move.

[Motion seconded, and carried unanimously.]

Doctor Stahmer: As the major part of its assignment, the Reference Committee reviewed in detail the financial reports referred to it: the WPS Operations Report for December 1966, the Treasurer's report, and the certified audits of all activities. Your Reference Committee on Finances delved extensively into the many financial aspects of the State Medical Society and all of its divisions. A number of questions were posed for discussion and were acceptably answered by staff and consulting CPAs. Furthermore, your Reference Committee is satisfied that WPS is a self-supporting activity and is not imposing any financial burdens on the State Medical Society per se.

I move acceptance of these financial reports.

[Motion seconded, and carried unanimously.]

Doctor Stahmer: In line with the financial statements referred to above, your Reference Committee recommends that dues continue in the same amount as at present for 1968.

I move acceptance of this portion of the report.

[Motion seconded, and carried unanimously.]

Doctor Stahmer: For informational purposes, this Reference Committee makes known its strong wish to be in close contact throughout the year with the Finance Committee of the Council (and particularly at the time of budget preparation) for purposes of closer communication. It requests that any financial reports involving any Society activity going to the Council Finance Committee be transmitted also to the House of Delegates Finance Committee.

There was also general discussion regarding a per diem stipend for the President of the State Medical Society during his year of office. Your Reference Committee recommends that this be referred to the Council for further consideration and subsequent report back to the House.

This concludes my report.

I now move acceptance of the report as a whole.

[Motion seconded and carried unanimously.]

Vice-Speaker Behnke: Is there any new business to come before the House at this time?

Doctor Bernhart: This is old business. Resolution F: "*Resolved*, that the State Medical Society of Wisconsin recommend full support of H.R. 6561 by the AMA."

I would like to refer again to Doctor Suckle's report, where he says, "The Reference Committee feels that safeguards should be taken for payment of the individual physician in a form that is acceptable to him after more experience is gained under the program."

I am a senior delegate and I will have to propose this at the AMA meeting. I would like to know whether or not this resolution will have the Reference Committee's "safeguard" statement at the bottom of it. May I ask Doctor Suckle about that?

Vice-Speaker Behnke: May I interpret Doctor Suckle's reply that the motion as stated with this has been approved by this House, and therefore should be included in your report. Correct, Doctor Suckle?

Doctor Bernhart: I am not so sure about that. This resolution has been passed now, and it is going to be transmitted to the delegates for transmission to the AMA with the recommendation that the safeguards will be instituted for the protection of the physician. I would think this resolution should have been changed a little bit in the final *Resolved*.

Speaker Callan: Is there any new business to come before this House?

Doctor Bernhart: I would like an answer to this old business.

Doctor Sievers: I agree with Doctor Bernhart. I feel very strongly about this. I read the report where

REFERENCE COMMITTEE ON FINANCES: Dr. L. R. Weinshel, Dr. J. W. McRoberts, Dr. A. H. Stahmer (chairman), Dr. R. L. Beilman, and Dr. F. D. Cook.

Zablocki stated his thoughts, and I do feel he is our friend in that report. It is like saying that the insurance company will pay the patient directly and the patient will pay us. I like to get checks directly from the insurance company.

Doctor Bernhart: May I have an expression from Doctor Suckle regarding this?

Vice-Speaker Behnke: Doctor Suckle, would you care to answer Doctor Bernhart? He is out of order, but we will let you answer anyhow.

Doctor Suckle: The Reference Committee felt that if it were the desire of the Congress to change the method of payment for the medical services under Medicare, they could change that, but we felt we didn't particularly care what they changed except that we felt it was important that safeguards be placed in there, that the individual physician be given the right to determine how he was to be paid, namely, as we stated before, 50 per cent of the physicians essentially accept assignments, and 50 per cent require that the patient be paid directly and then pay them.

We took cognizance of the fact in our Reference Committee proceedings that patients may obtain the money from the Government and then refuse to pay the doctor, and that is why we put in the safeguard that the physician should determine how he would be paid.

We also took into consideration the fact that it may be necessary, too, that if the patient is paid directly, the check may have to have a double title, namely, the doctor as well as the patient so that the patient alone cannot cash it.

We felt that regardless of what the Government did or what the House of Representatives might do in changing the method of payment under Medicare, there should be safeguards for the payment of the physician, and that the method of payment should be left to the physician and not just to the Government alone. That is why we put in this additional wording.

As further background material, Doctor Bernhart, in discussing this with me, stated that he felt that Clement Zablocki's resolution was an important thing, something that we should go along with, that he did not accept assignments and that many of the doctors in Milwaukee did not accept assignment and they didn't care whether anyone else accepted assignment; but in acting for the entire State Medical Society the Reference Committee felt we should take recognition of the fact that again a great portion of our membership does accept assignment and therefore we again should leave it to the individual physician's choice.

Vice-Speaker Behnke: Thank you, Doctor Suckle.

The Chair rules any further discussion of this matter is out of order.

WEDNESDAY MORNING SESSION

May 10, 1967

The third session of the House of Delegates convened at 9:15 a.m., Drs. R. E. Callan, Speaker, and G. A. Behnke, Vice-speaker, presiding.

INTRODUCTION OF GUEST

Speaker Callan: It is my privilege to introduce Dr. Lawrence C. Meredith, President of the Ohio State Medical Association.

■ REPORT OF COMMITTEE ON NOMINATIONS —May 1967

Dr. C. J. Picard (Douglas): The 1967 report of the Nominating Committee is composed of one delegate from each Councilor District. We have the honor and pleasure to present the following nominees for the various positions in the State Medical Society of Wisconsin:

For the office of President-elect: Dr. W. D. James of Oconomwoc.

For the office of Speaker of the House for a two-year term: Dr. George Behnke of Kaukauna.

For the office of Vice-speaker for a one-year term: Dr. T. J. Nereim of Madison.

For the office of Delegates to the AMA: Dr. W. B. Hildebrand of Menasha to succeed himself. Dr. R. E. Galasinski of Milwaukee to succeed himself.

For the office of Alternate Delegates to the AMA: Dr N. A. Hill of Madison to succeed himself. Dr. G. E. Collentine, Jr. of Milwaukee to succeed himself. This is for the year 1968–1969.

The choice for the next meeting place was not left up to this Committee, but I wish to make this announcement because it ordinarily is a function of this Committee. We are committed through 1970, so we will not bring it up now.

ELECTION OF OFFICERS

[The following nominees were elected unanimously.]

PRESIDENT-ELECT: W. D. James, M.D., Oconomowoc (one-year term).

SPEAKER OF THE HOUSE: G. A. Behnke, M.D., Kaukauna (two-year term).

VICE-SPEAKER OF THE HOUSE: T. J. Nereim, M.D., Madison (one-year term).

ELECTION OF DELEGATES

[The following nominees were elected unanimously to succeed themselves.]

AMA DELEGATE: W. B. Hildebrand, M.D., Menasha (two-year term: 1968–1969).

AMA DELEGATE: R. E. Galasinski, M.D., Milwaukee (two-year term: 1968–1969).

AMA ALTERNATE DELEGATE: N. A. Hill, M.D., Madison (two-year term: 1968–1969).

AMA ALTERNATE DELEGATE: G. E. Collentine, Jr., M.D., Milwaukee (two-year term: 1968–1969).

ELECTION OF COUNCILORS

[The following nominees were elected unanimously to succeed themselves unless otherwise indicated.]

Third District _____ E. J. Nordby, M.D., Madison
Fourth District ___ H. W. Carey, M.D., Lancaster
Fifth District __ J. W. McRoberts, M.D., Sheboygan (succeeding P. B. Blanchard, M.D., Cedarburg)
Sixth District ____ J. A. Sisk, M.D., Fond du Lac
Twelfth District __ W. J. Egan, M.D., Milwaukee
J. M. Sullivan, M.D., Milwaukee (new Councilor position)

REPORT OF THE CREDENTIALS COMMITTEE

Doctor Roethke: The Committee on Credentials has verified the registration of 60 delegates and 10 alternate delegates entitled to vote at this session of the House of Delegates, representing 40 county medical societies and 7 sections.

Also, the Credentials Committee has been informed that the following will act as delegate for the regular delegate and alternate who are unable to attend:

G. C. Hillery for Grant
Thomas Jennings for Milwaukee
R. D. Heinen for Oconto
R. E. Church for the Public Health Section
W. B. Gallagher for La Crosse
Owen Larson for Winnebago

I move that the attendance roll of delegates, alternates and specially appointed delegates, totaling 76, so compiled by the Credentials Committee, be accepted as the official roll of this session of the House.

[Motion seconded and carried unanimously.]

[Dr. W. D. James, Oconomowoc. was escorted to the platform, and the audience arose and applauded.]

REMARKS OF NEW PRESIDENT-ELECT

Dr. W. D. James: I want to thank you for awarding me the highest honor that you can in electing me to this office. I approach the podium today with mixed feelings of pride and humility. I will do the best I can to fulfill the duties of this office and to carry on the traditions of the men who have preceded me.

REMARKS OF THE SECRETARY

Secretary Crownhart: I would remind the House that at the Annual Dinner of the Society it will honor itself as well as honor two men. One of them is a nationally known figure in the house of medicine, and he will be here from Washington, D. C. The other is a well-known State figure, who will come over from Madison. I hope our affair tonight will be a successful one, conducted with some humility toward the two who are receiving high distinction.

. . .

I would like to say that I am highly appreciative (as I am sure you are) of all the staff cooperation. I sit up here and it looks like I am the only one, but there are a lot of people behind the scenes. This year Dave Reynolds has taken over as Director of Scientific Activities. This is his first Annual Meeting with that responsibility, and if you see him please tell him what you think about it. I hope it is in praise.

Mr. Speaker, I would like to thank you for six years of holding me down. We read Robert's Rules of Order ahead of time, and the only time he confuses me is when he calls for a negative vote before he calls for the affirmative; but he always seems to be right. My thanks to the delegates and officers.

RESOLUTION OF APPRECIATION

Speaker Callan: Is there any new business?

President Drew: I have two matters I would like to bring before the House at this time. One is a resolution of appreciation.

Man can receive many gifts and rewards in his life that are offered in appreciation. Many are of value in one form or another. The greatest award a man can receive is the deep, sincere thank you for service well done. This thank you has been offered many times in the past six years.

Some men, in performance of their duty, can excel in knowledge, performance, and execution of their duty. Dr. Robert Callan has met all these requirements as Speaker of this House of Delegates for the past six years. He has shown great leadership and devotion, and great knowledge of parliamentary law.

He has been fair, just, and firm at all times. These are the sterling qualities of a great leader and statesman.

Dr. Robert E. Callan has earned all these accolades as a well-deserved and fitting tribute to him as he departs from this high office. As President of the State Society, and speaking for the entire membership of the Society and particularly the House of Delegates, I again say thank you to Bob for his magnificent job well done. It has been perfection at its peak.

I request that this tribute be entered in the records of this House and a copy sent to Speaker Robert E. Callan.

[The House arose and applauded.]

MOTION ON SELF-PROTECTIVE MECHANISMS

President Drew [continuing]: I have another resolution.

With permission of the House of Delegates, and at the request of many members of the Society, I would like to ask permission and approval of the self-protection mechanisms as outlined in the March issue of the *Wisconsin Medical Journal* on the President's Page, entitled, "From the Sublime to the Ridiculous".

This philosophy is new to medicine, but not to many other areas of endeavor. Authorization is requested that as your President I may appoint a committee of five members to review the legal requirements necessary and the method needed to implement this protective mechanism, and report to the membership at an early date in a communication to be sent to each member.

I offer that in the form of a motion.

[Motion seconded and carried unanimously.]

VOTE OF COMMENDATION TO THE STAFF

President Drew [continuing]: I would be very derelict in my duty if I did not thank Mr. Crownhart and his staff for the superior cooperation of the business side of medicine that I have received in the past year. We could not have a more dedicated group, and I doubt whether any could be assembled. I trust that this splendid understanding that exists between the officers and the staff will continue and grow, as it is the foundation of the house of medicine. A weak foundation is no foundation at all, and a division of such a house is costly and futile.

I thank you, Mr. Crownhart, for all you have done during my year as President.

REMARKS OF THE SPEAKER

Speaker Callan: I want to thank you for your kind expression of appreciation, if you want to call it that. I don't feel that way. I feel it has been a privilege for me to have served you in the past six years, and I want to thank you for having given me the opportunity.

At this time I would like to thank Dr. P. B. Blanchard, Councilor from Cedarburg, for his long years of service to the Society.

Also, I would be remiss as your Speaker if I did not thank our reference committees—Doctor Strang, of the Reference Committee on Reports of Officers; Doctor Hilliard of the Reference Committee on Reports of Standing Committees; Doctor Suckle, Chairman of the Reference Committee on Resolutions and Amendments to the Constitution and Bylaws, and Doctor Stahmer, Chairman of the Reference Committee on Finances, and all our colleagues on these committees who have done such a fine job. I think ultimately we will make the understanding of our financial structure one that will prevent further misconceptions and difficulties. Also, Dr. Anne Roethke for her efforts and those on the Credentials Committee.

I had planned to thank the staff. Charlie did so himself, but on behalf of the House I want to thank all of them. They have been most effective, starting with Mr. Crownhart, our Secretary and General Manager, who is behind the scenes pulling all the right strings at the right time. Also, Joan Pyre, Jean Anderson, both Mr. Murphys; Robert, our legal counsel, and Tom, our public relations director. Mr. Kluwin, our associate legal counsel. Howard Brower, Norman Salt, Bernie Maroney, and David Reynolds for arranging the scientific meeting over at the Auditorium. Charlotte Emmons, our stenotype reporter, and all the numerous staff members who have contributed so much. On behalf of the House of Delegates I wish to thank them.

COUNCILOR ELECTION

Doctor Urbanek: One order of business might be brought up now. With the election of Doctor James to the office of President-elect, the First District is without a Councilor. If it is in order I would like to nominate a Councilor.

Speaker Callan: Has the First District caucused to decide on a candidate?

Doctor Urbanek: Yes.

Speaker Callan: Then you are in order. . . . Who is the nominee?

Doctor Urbanek: The First District would like to nominate Dr. Howard Bayley of Beaver Dam.

Speaker Callan: Are there any other nominations from the First District? Hearing none, a motion is in order to close nominations and to cast the unanimous ballot for Doctor Bayley as Councilor.

Doctor Bernhart: I so move.

[Motion seconded and carried unanimously.]

Speaker Callan: Doctor Bayley is unanimously elected Councilor of the First District to succeed Doctor James.

Doctor Bernhart: I move we adjourn.

[Motion severally seconded and carried unanimously.]

[The House adjourned *sine die* at 9:50 a.m.]

■ ATTENDANCE AT HOUSE OF DELEGATES—May 1967

SOCIETY:	Sessions 1	X	2	3
Ashland—Bayfield—Iron				
W. E. Bargholtz, Ashland	o	o	o	o
J. M. Jauquet, Ashland	x	x	o	x
Barron—Washburn—Sawyer—Burnett				
C. J. Strang, Barron	x	o	x	x
Robert Anderson, Cumberland	o	o	o	o
Brown				
F. D. Cook, Green Bay	x	x	x	x
R. A. McCormick, Green Bay	o	o	o	o
J. B. Grace, Green Bay	x	x	x	x
Lyle H. Edelblute, Green Bay	x	o	o	o
Donel Sullivan, Green Bay	x	x	x	x
Henry Rahr, Green Bay	x	x	x	x
Calumet				
E. W. Humke, Chilton	o	o	o	o
J. C. Pinney, Hilbert	o	o	o	o
Chippewa				
M. W. Asplund, Bloomer	o	o	o	o
J. J. Sazama, Chippewa Falls	o	o	o	o
Clarence Zenner, Cadott (specially appointed)	x	o	o	o

First name is delegate, indented name is alternate. x—present, o—absent, X—extraordinary session.

SOCIETY:	Sessions 1	X	2	3
Clark				
E. D. Pfefferkorn, Colby	x	x	x	o
J. W. Koch, Colby	o	o	o	o
Columbia–Marquette–Adams				
R. T. Cooney, Portage	x	x	x	x
R. R. Rueckert, Portage	x	x	o	x
Crawford				
T. F. Farrell, Prairie du Chien	x	x	x	x
M. S. Garrity, Prairie du Chien	o	o	o	o
Dane				
Robert L. Beilman, Madison	x	x	x	x
R. W. Shropshire, Madison	x	x	x	x
George A. Benish, Madison	x	x	x	x
C. Weir Horswill, Madison	o	x	x	x
John V. Berger, Jr., Madison	x	o	x	o
Paul O. Simenstad, Madison	o	o	o	x
W. P. Crowley, Madison	x	x	x	x
J. J. Brandabur, Madison	o	o	o	o
G. J. Derus, Madison	x	x	x	x
E. E. Johnson, Madison	o	o	o	o
J. H. Morledge, Madison	x	o	x	o
P. G. Piper, Madison	o	o	o	o
John F. Morrissey, Madison	x	o	o	o
Thomas C. Meyer, Madison	o	x	x	x
T. J. Nerein, Madison	x	x	o	x
P. J. Schoenbeck, Stoughton	x	o	x	x
G. E. Oosterhous, Madison	o	o	x	x
L. G. Crocker, Madison	x	x	o	o
W. T. Russell, Sun Prairie	x	x	x	o
E. I. Boldon, Madison	o	o	o	o
K. L. Siebecker, Madison	x	x	x	x
D. A. Peterson, Madison	o	o	o	o
H. M. Suckle, Madison	x	x	x	o
J. F. McIntosh, Madison	o	o	o	o
Dodge				
R. E. Urbanek, Beaver Dam	x	x	x	x
W. G. Richards, Beaver Dam	x	x	o	o
Door–Kewaunee				
Patricia Lanier, Kewaunee	o	o	o	o
W. G. Sheets, Sturgeon Bay	o	x	x	x
Douglas				
C. J. Picard, Superior	x	x	x	x
I. H. Lavine, Superior	x	x	x	x
Eau Claire–Dunn–Pepin				
A. A. Drescher, Menomonie	x	x	x	x
G. G. Giffen, Eau Claire	o	o	o	o
Ralph Hudson, Eau Claire	x	x	x	x
Thomas D. Moberg, Eau Claire	o	o	o	o
Fond du Lac				
W. E. Myers, Fond du Lac	x	x	x	x
W. G. Kendell, Fond du Lac	o	o	o	o
D. J. Twohig, Jr., Fond du Lac	x	x	x	x
Howard Mauthe, Fond du Lac	x	o	o	o
Forest				
B. S. Rathert, Crandon	o	o	o	o
E. R. Castaldo, Laona	o	o	o	o
Grant				
C. E. Mueller, Boscobel	o	o	o	o
K. L. Bauman, Lancaster	o	o	o	o
G. C. Hillery, Lancaster (specially appointed)	x	x	x	x
Green				
R. G. Zach, Monroe	x	x	x	x
W. J. Staab, Jr., Monroe	x	x	o	x
Green Lake–Waushara				
David J. Sievers, Berlin	o	x	x	x
L. J. Seward, Berlin	x	o	o	o
Iowa				
W. D. Hamlin, Mineral Point	x	x	x	x
S. B. Marshall, Hollandale	o	o	o	o

SOCIETY:	Sessions 1	X	2	3
Jefferson				
M. G. Peterson, Lake Mills	x	x	x	o
R. R. Liebenow, Lake Mills	o	o	o	x
Juneau				
V. M. Griffin, Mauston	o	x	x	o
Jack Strong, Mauston	o	o	o	o
Kenosha				
Louis Olsman, Kenosha	x	x	x	x
F. C. Williams, Kenosha	o	o	o	o
Morris Siegel, Kenosha	x	x	x	x
G. F. Armstrong, Kenosha	o	o	o	o
La Crosse				
D. L. Morris, West Salem	x	x	x	o
Frederick H. Wolf, La Crosse	o	o	o	o
W. B. Gallagher, La Crosse (specially appointed)	o	o	o	x
G. B. Murphy, Jr., La Crosse	x	x	x	x
Mark O'Meara, La Crosse	o	o	o	o
John J. Satory, La Crosse	o	x	x	x
Paul W. Phillips, La Crosse	o	o	o	o
Lafayette				
R. E. Hunter, Argyle	o	o	o	o
D. F. Ruf, Darlington	x	x	x	o
Langlade				
T. C. Fox, Antigo	x	x	x	x
R. W. Cromer, Antigo	o	o	o	o
Lincoln				
R. J. Henderson, Tomahawk	o	o	o	o
J. F. Bigalow, Merrill	x	x	x	x
Manitowoc				
T. H. Rees, Manitowoc	o	x	x	o
W. F. Smejkal, Manitowoc	x	o	o	x
Marathon				
R. B. Larsen, Wausau	x	x	x	x
J. D. Kramer, Wausau	o	o	o	x
A. H. Stahmer, Wausau	x	x	x	x
G. R. Hammes, Wausau	o	o	o	o
Marinette–Florence				
C. E. Koepp, Marinette	x	x	x	x
Antoine Barrette, Peshtigo	o	o	o	o
Milwaukee				
E. L. Bernhart, Milwaukee	x	x	x	x
J. D. Silbar, Milwaukee	x	x	o	o
Bruce J. Brewer, Milwaukee	o	o	o	o
Vacancy				
J. W. Sargent, Milwaukee (specially appointed)	x	o	o	x
Robert W. Byrne, Milwaukee	x	x	x	x
Vacancy				
D. W. Calvy, Wauwatosa	x	o	o	o
D. K. Schmidt, Milwaukee	o	o	x	o
D. J. Carlson, Milwaukee	x	x	x	x
R. B. Pittelkow, Milwaukee	x	x	o	x
W. L. Coffey, Milwaukee	x	x	x	o
W. H. Frackelton, Milwaukee	o	o	o	o
G. E. Collentine, Jr., Milwaukee	x	o	x	x
John Bareta, Milwaukee	o	o	o	o
E. G. Collins, West Allis	x	x	x	o
J. W. Sargent (vacated)				
H. R. Foerster, Jr., Milwaukee (specially appointed)	o	o	o	o
T. J. Cox, Milwaukee	x	o	x	x
R. F. Barta, Elm Grove	x	x	o	x
G. W. Dean, Milwaukee	x	x	x	x
R. J. Snartemo, Milwaukee	x	x	x	x
Norbert Enzer, Milwaukee	x	x	x	x
R. H. Lillie, Milwaukee	o	o	o	o
W. E. Finlayson, Milwaukee	x	x	x	x
R. P. Le Tellier, Milwaukee	o	o	o	o
G. F. Flynn, Milwaukee	x	x	x	x
J. D. Hurley, Milwaukee	o	o	o	o
T. J. Foley, Milwaukee	x	o	o	o
C. P. Erwin, Elm Grove	o	o	x	o

SOCIETY:	Sessions 1	X	2	3
G. W. Hilliard, Milwaukee	x	x	x	x
T. F. Jennings (vacated)				
R. L. Franklin, Milwaukee (specially appointed)	x	o	o	o
G. S. Kilkenny, Milwaukee	x	x	o	o
W. C. Webb, Milwaukee	o	o	o	o
P. G. LaBissoniere, Milwaukee	x	o	x	x
F. L. Ziehl, Milwaukee	o	o	o	o
Roger Laubenheimer, Milwaukee	x	o	o	x
A. R. Pequet, Milwaukee	x	x	x	x
Mischa J. Lustok, Milwaukee	o	o	o	o
W. C. Curtis, Wauwatosa	o	o	o	o
F. J. Millen, Milwaukee	x	o	x	x
W. V. Baker, Wauwatosa	o	o	o	o
George V. Murphy, South Milwaukee	x	x	o	o
R. H. Frederick, West Allis	o	o	o	o
J. R. O'Connell, Wauwatosa	x	x	x	x
W. J. Boulanger, Milwaukee	o	o	o	o
Anne Roethke, Milwaukee	x	x	x	x
R. R. Watson, Milwaukee	o	o	o	o
F. A. Ross, Milwaukee	x	x	x	o
L. L. Larsen, Milwaukee	o	o	o	o
D. M. Ruch, Milwaukee	x	o	o	o
K. A. Liefert, Wauwatosa	o	o	o	o
T. F. Jennings, Milwaukee (specially appointed)	x	o	x	x
A. J. Sanfelippo, Milwaukee	x	x	x	x
G. H. Franke, Milwaukee	o	o	o	o
K. E. Sauter, Milwaukee	x	x	x	x
M. E. Sattler, Milwaukee	o	x	o	x
E. J. Schmidt, Wauwatosa	x	x	x	x
R. A. Nimz, Milwaukee	o	o	o	o
R. T. Sproule, Milwaukee	x	x	x	x
Marvin Glicklich, Milwaukee	x	o	o	x
H. F. Twelmeyer, Wauwatosa	x	o	x	x
B. M. Zimmermann, Milwaukee	x	o	o	o
L. R. Weinshel, Milwaukee	x	x	o	x
T. L. Calvy, Milwaukee	o	o	o	o
E. D. Wilkinson, West Allis	x	x	x	x
D. P. Babbitt, Milwaukee	o	o	o	o
S. E. Zawodny, Milwaukee	x	x	x	x
J. J. Frederick, Cudahy	x	x	o	x
Monroe				
R. G. Konicek, Tomah	x	o	o	x
Jack Brown, Sparta	o	x	o	o
Oconto				
C. E. Siefert, Oconto Falls	o	o	o	o
J. R. Culver, Oconto Falls	o	o	o	o
Robert D. Heinen, Oconto (specially appointed)	x	x	x	x
Oneida—Vilas				
Marvin Wright, Rhinelander	o	x	o	o
Henry S. Ashe, Minocqua	x	o	x	x
Outagamie				
J. G. Bergwall, Hortonville	x	x	x	x
W. H. Hale, Appleton	o	o	o	o
William R. Richards, Appleton	o	o	o	x
G. A. Behnke, Kaukauna	x	x	x	o
Ozaukee				
R. H. Dorr, Belgium	x	x	x	x
J. F. Walsh, Port Washington	o	x	x	o
Pierce—St. Croix				
C. A. Olson, Baldwin	x	x	x	x
John May, Baldwin	x	x	o	x
Polk				
L. O. Simenstad, Osceola	o	x	x	x
Marwood E. Wegner, St. Croix Falls	x	x	o	x
Portage				
F. E. Gehin, Stevens Point	x	x	x	x
R. H. Bickford, Stevens Point	x	o	x	x
Price—Taylor				
W. W. Meyer, Medford	x	o	x	x
J. D. Leahy, Park Falls	o	o	o	o

SOCIETY:	Sessions 1	X	2	3
Racine				
William Henken, Racine	x	x	x	x
Joseph C. Fralich, Racine	o	o	o	o
William J. Little, Racine	x	o	o	x
William J. Smollen, Racine	x	x	o	o
W. H. Williamson, Racine	x	x	x	x
Marvin W. Nelson, Racine	o	o	o	o
Richland				
R. W. Edwards, Richland Center	x	x	x	x
George Parke, Richland Center	o	o	o	o
Rock				
R. M. Baldwin, Beloit	x	x	x	x
C. M. Carney, Beloit	x	o	o	o
Jordon Frank, Beloit	x	x	x	x
Allen O. Tuftee, Beloit	o	o	o	o
M. F. Purdy, Janesville	x	x	x	x
J. R. Schroder, Janesville	o	o	o	o
Rusk				
W. B. A. J. Bauer, Ladysmith	o	o	o	o
Howard F. Pagel, Ladysmith	o	o	o	o
Sauk				
E. V. Stadel, Reedsburg	o	o	o	o
Eugene Weston, Baraboo	x	x	o	x
Shawano				
William Grover, Bonduel	o	o	o	o
Patricia J. Stuff, Bonduel	x	x	x	x
Sheboygan				
Joseph F. Kovacic, Sheboygan	x	o	x	x
Irvin L. Schroeder, Sheboygan	o	x	o	o
J. W. McRoberts, Sheboygan	x	x	x	x
Robert M. Senty, Sheboygan	x	x	x	x
Trempealeau—Jackson—Buffalo				
E. P. Rohde, Galesville	x	x	x	o
W. E. Wright, Mondovi	x	o	o	x
Vernon				
Robert A. Starr, Viroqua	x	x	x	x
Thomas Boston, Hillsboro	o	o	o	o
Walworth				
E. D. Sorenson, Elkhorn	x	x	x	x
R. S. Galgano, Delavan	o	o	o	o
Washington				
E. C. Quackenbush, Hartford	x	x	x	o
W. A. Nielsen, West Bend	o	o	o	o
Waukesha				
J. J. Foley, Menomonee Falls	x	x	o	o
Richard G. Frantz, Waukesha	o	o	x	o
Vacancy				
D. P. Nachazel, Jr., Waukesha	x	x	x	x
P. M. Wilkinson, Oconomowoc	x	x	x	x
J. R. Matt, Oconomowoc	o	x	o	x
Waupaca				
William G. Arnold, Clintonville	o	o	o	o
Robert Reichle, Clintonville	o	o	o	o
Winnebago				
S. J. Graiewski, Oshkosh	x	x	x	o
Thomas M. Kivlin, Oshkosh	o	o	o	o
John R. McKenzie, Jr., Oshkosh	x	x	x	x
Glenn E. Gustafson, Jr., Menasha	o	o	o	o
Paul E. Wainscott, Menasha	x	o	x	o
H. J. Colgan, Neenah	o	o	o	o
Owen E. Larson, Menasha (specially appointed)	o	o	o	x
Wood				
E. C. Glenn, Port Edwards	o	o	o	o
John E. Thompson, Nekoosa	x	x	o	x
Russell F. Lewis, Marshfield	o	x	x	x
Nelson A. Moffat, Marshfield	x	x	o	o

SECTION:	Sessions 1	X	2	3
Anesthesiology				
Harry Thimke, Eau Claire	o	o	o	o
David Noll, Madison	o	o	o	o
Dermatology				
Joel Taxman, Milwaukee	x	x	x	o
G. O. Stubenrauch, Milwaukee	o	o	o	o
General Practice				
R. R. Richards, Eau Claire	x	o	o	x
Eugene Kay, Milwaukee	x	x	x	x
Internal Medicine				
John M. Irvin, Monroe	o	o	o	o
James A. Means, Milwaukee	o	x	x	x
Medical Faculties				
O. O. Meyer, Madison	x	o	o	x
E. A. Bachhuber, Milwaukee	o	x	o	o
Neurology—Psychiatry				
Joseph G. Brown, Madison	x	x	x	o
B. Cullen Burris, Milwaukee	o	o	o	o
Obstetrics—Gynecology				
William J. Madden, Racine	x	x	x	x
R. E. Whitsitt, Madison	o	o	o	o
Ophthalmology				
Arthur Kissling, Milwaukee	x	o	x	x
C. F. Schmidt, La Crosse	o	o	o	o

SECTION:	Sessions 1	X	2	3
Orthopedics				
Peter Golden, Madison	x	x	x	x
C. Hugh Hickey, Jr., Milwaukee	o	o	o	o
Otolaryngology				
Watson B. Larkin, Eau Claire	x	x	x	x
John K. Scott, Madison	o	o	o	o
Pathology				
Lars W. Kleppe, Beloit	o	o	o	o
Robert A. Scheidt, Milwaukee	x	o	x	x
Pediatrics				
Richard L. Myers, Green Bay	x	x	x	x
J. R. Guy, Waukesha	o	o	o	o
Public Health				
C. K. Kincaid, Madison	o	o	o	o
G. M. Shinners, Green Bay	x	o	o	o
Ruth E. Church, Waukesha (specially appointed)	x	x	o	x
Radiology				
W. M. Rounds, Madison	x	x	x	o
A. B. Fidler, Milwaukee	o	o	o	o
Surgery				
J. M. Sullivan, Milwaukee	x	x	x	x
B. J. Longley, Madison	o	o	o	o
Urology				
J. P. McCann, La Crosse	o	o	o	o
J. W. Kearns, Milwaukee	o	x	x	o

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Among the many projects which are supported by this method is the Medical Student Loan Fund. Since the integration of the loan fund into the Foundation in 1955, the student loan aspects of the program have grown.

Every practicing physician recognizes the unquestionable need for timely aid to the kin of his profession who face unusual financial hardship. Personal hardship strikes at physicians and their families as well as others. Through the Foundation there is an opportunity for professional persons to assist their colleagues who suffer adversity.

The Scientific medicine activities of the Foundation include circuit teaching programs, speakers service for county medical societies, and the support of research in many fields in cooperation with other agencies.

The Foundation has not neglected the value of learning from the past and the Museum of Medical Progress and Stovall Hall of Health, reconstruction of the Fort Crawford Hospital in Prairie du Chien, have made many visitors aware of the role that medicine has and is playing in their lives.

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Use of Brain Scanning for Evaluation of the Mentally Disturbed Patient

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Madison, Wisconsin

■ PSYCHIATRIC SYMPTOMS may obscure the presence of underlying organic brain disease, particularly neoplasms. There have been numerous reports of patients with intracranial tumors in whom mental symptoms were either the essential feature or overshadowed isolated neurological findings.[1-6] The problem of brain tumor diagnosis in the elderly is compounded by the ease with which mental changes may be attributed to arteriosclerosis and senility. Reports based on routine autopsies performed in mental hospitals have shown that 2% to 4% of deaths are associated with intracranial neoplasms. These studies also confirm the fact that symptoms may be varied with no distinct patterns to indicate the presence of organic disease.

The purpose of this communication is to call attention to the use of brain scanning as a rapid, safe diagnostic method for screening of the psychiatric patient for the presence of intracranial tumor. Case histories of three patients recently examined in our laboratory are presented to emphasize the lack of localizing diagnostic clinical symptoms and signs even with large tumors and to illustrate the definitive localization of brain tumors by scanning. Briefly, brain scanning refers to the systematic mapping of the distribution of a radiopharmaceutical in the various tissues of the head. Familiarity with the patient history, physical examination, laboratory data, the radiopharmaceutical, and the scanning instrument aid the clinician in determining whether the scan image is normal or abnormal. In localization of brain tumors, the radiopharmaceutical is highly concentrated in the area of the lesion by one or more of the following mechanisms: (1) tumor neo-vascularization, (2) breakdown of the blood-brain barrier with diffusion of the radiopharmaceutical into the extracellular fluid, and (3) actual cellular fixation of the radiopharmaceutical in the tumor.

CASE REPORTS

Case 1. This 65-year-old female school teacher was admitted to the hospital in February 1967. One year prior to admission she had noted the onset of absent mindedness. This was characterized by forgetting the names of her students and friends. She had difficulty maintaining interest in her job. On one occasion she slept through Monday classes thinking it was Sunday. Normal movements were performed with decreased speed.

The only abnormal physical finding was equivocal drift of the left upper extremity.

Brain scanning with technetium-99m (Tc-99m) demonstrated the presence of a large space-occupying lesion in the right frontal area (Fig 1). Electroencephalographic studies also revealed the presence of a cortical destructive process greatest in the right frontal area. Subsequent carotid arteriography confirmed the presence of a tumor mass in the right frontal lobe.

Three days after admission a right frontal craniotomy was performed with removal of a meningioma containing both meningocytic and fibroblastic components.

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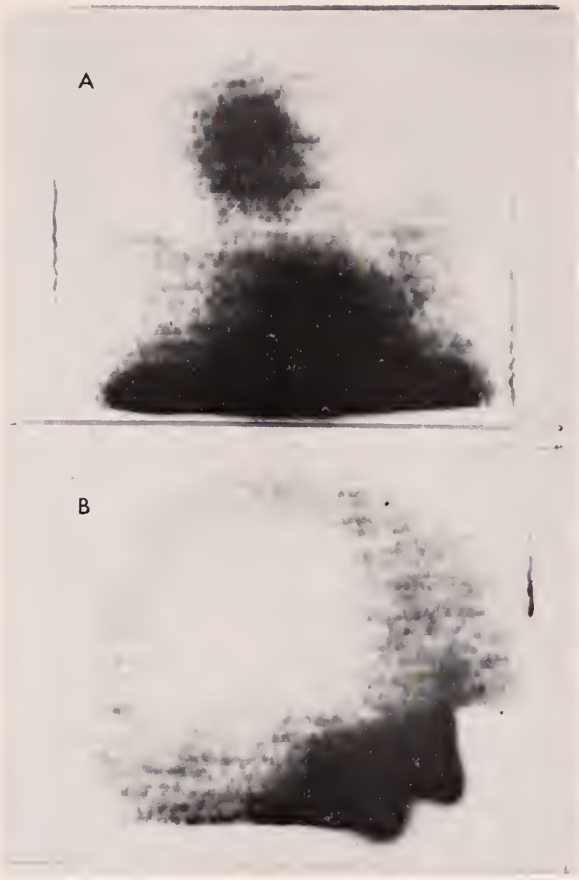

Fig. 1—Anterior (A) and right lateral brain (B) scans performed with Tc^{99m} in case 1. Large black area in anterior view indicates site of neoplasm, beneath which is noted the activity in the nasopharyngeal blood pool and highly vascular tissues of the facial region. The right lateral scan indicates the lesion involves the frontal lobe.

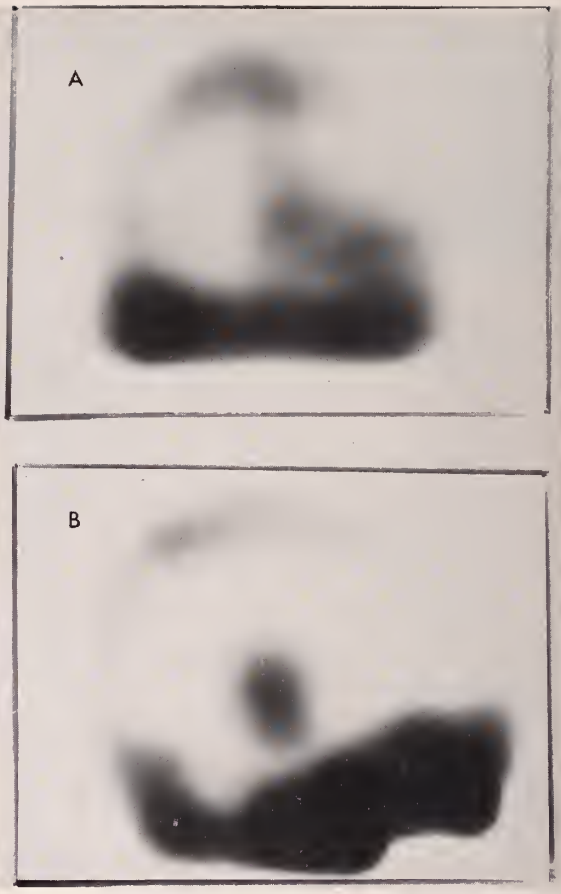

Fig. 2—Posterior (A) and right lateral (B) brain scans in case 2. This lesion was a meningioma within the right lateral ventricle. The position on the right lateral scan corresponds to the site of the choroid plexus and trigone of the lateral ventricle.

Case 2. In June 1966 this 44-year-old housewife was admitted to the hospital in a state of marked agitation. The patient had a history of grand mal seizures beginning in childhood. An electroencephalogram in 1961 revealed bitemporal spiking consistent with seizures. During the two days prior to admission she had experienced three grand mal seizures preceded by visual aura and followed by severe anxiety, agitation, and bifrontal headaches. She was managed with amobarbital (Amytal) and diphenylhydantoin sodium (Dilantin). She also yielded symptoms of severe depression and auditory hallucinations.

Physical examination was hampered by the patient's mental status as well as superimposed effects of medication. Repeated examinations showed tremor of both hands and a slight abnormality in finger-to-nose testing. There were no other definitely abnormal findings. The admitting diagnosis was acute psychotic reaction, depressive type, etiology unknown.

Electroencephalogram demonstrated a focal disturbance in the right posterior Sylvian temporal area. Brain scanning with Tc-99m (Fig 2) revealed a large focus of increased activity in the right parietal region indicating a space-occupying lesion. Scan findings were confirmed by carotid arteriography.

A right temporal craniotomy was performed and an intraventricular meningioma, fibroblastic type, arising from the stroma of the choroid plexus, was removed completely.

After a benign postoperative course, the patient has continued to improve and is seizure free on medication.

Case 3. Reported ingestion of 80 to 100 reserpine tablets precipitated the admission of this 78-year-old retired tailor to the hospital in January 1967. Two weeks previously he had been noted to be despondent stating that he was a burden on his family. Five days preceding admission he attempted suicide by electrocution.

Positive physical findings included a fine tremor of both hands with moderate cog-wheeling of his right upper extremity and mild cog-wheeling of the opposite member. He walked with a slow shuffling gait.

Electroencephalographic studies revealed a focal disturbance in the right posterior temporal-parieto-occipital region. Brain scan with Tc-99m demonstrated a large space-occupying lesion in the right occipital area (Fig 3).

Craniotomy performed four weeks after admission revealed a calcifying meningioma, psammoma type, arising from the falx. The patient suffered a cardiac arrest and died on the third day after surgery. Postmortem examination demonstrated a recent anterior wall myocardial infarction.

COMMENT

Brain scanning is a simple, safe, and remarkably accurate means of screening patients for the presence of space-occupying neoplasms. The scan defines both the site and size of the lesion. Reports of accuracy of this technique range from 70% to more than 90%.[7-9] As Murphy has pointed out, essentially atraumatic evaluation for the presence of supratentorial tumors may be accomplished using the combination of the brain scan and the electroencephalogram with an anticipated accuracy up to 97%.[9] In only 3% of Murphy's series were both studies negative. In the three cases presented above, both the scan and the EEG indicated abnormalities. Brain scanning is most accurate in meningiomas and glioblastomas. Metastatic tumors and neoplasms with low histological grading are somewhat more difficult to visualize.[7,8]

The thread linking the three case histories outlined previously is a disturbance of behavior. There were no consistent or specific neurologic patterns. The neoplasms occurred in three distinctly different sites: frontal, intraventricular, and occipital. Brain scanning permitted ready demonstration of space-occupying disease. In case 2, the patient has been able to resume a relatively normal life. In this instance a minimal suspicion on the part of the referring physician has proved to be of incalculable value to the patient involved. Unfortunately, there are no available statistics on the proportion of psychiatric patients having positive brain scans. Further study of this point might result in an increased salvage of patients with apparent or real mental illness.

SUMMARY

Brain scanning may be applied to the evaluation of patients with behavioral disturbances secondary to intracranial neoplasms with positive results. The combined use of brain scanning and electroencephalography are complementary and unassociated with hazard. Routine inclusion of brain scanning in the psychiatric examination needs further evaluation.

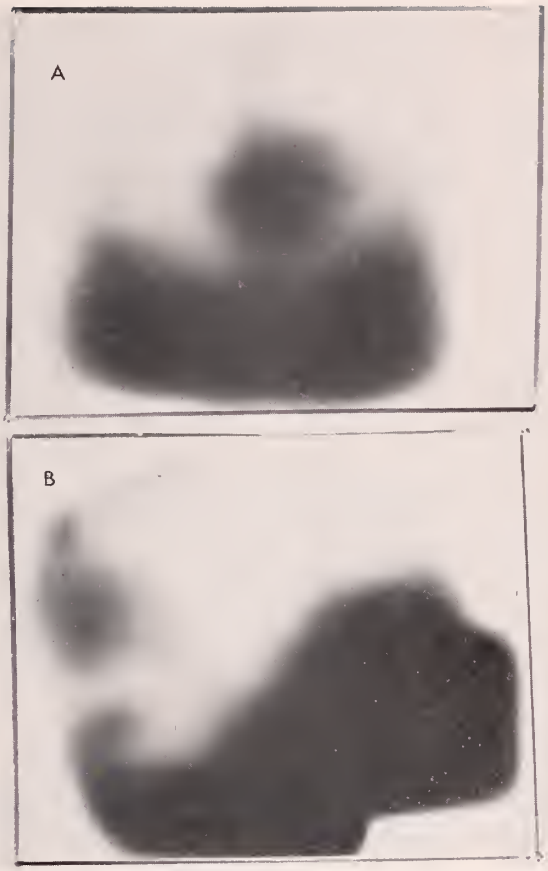

Fig. 3—Posterior (A) and right lateral (B) brain scans obtained in case 3. The posterior view indicates a large lesion extending to the midline while the lateral view indicates the lesion to be occipital and extending to the brain surface. The torcular Herophili is inferior to the lesion.

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Postmastectomy Lymphangiosarcoma

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■ STEWART AND TREVES[1] in 1948 reported a previously unrecognized clinical entity, associated with lymphedema of the upper extremity, in patients who had undergone radical mastectomy for carcinoma of the breast. This syndrome, although well established, has recently been questioned by Salm,[2] who favors the concept that these lesions are produced as a result of "retrograde metastases" from carcinoma of the breast.

Since the original report by Stewart and Treves,[1] a number of cases have been described in the literature. Taswell et al,[3] reviewed the literature in 1962 and with the addition of their own cases brought the total to 64. Of these, 58 were associated with a lymphedematous upper extremity following radical mastectomy. Khodadadeh[4] in 1963 reviewed the world medical literature and brought the figure to 76. Fisher[5] reported 4 cases in 1965. Recently we have had the opportunity of observing a patient with this lesion.

CLINICAL SYNDROME

The classical sequence of events[1] is the appearance of chronic lymphedema on the ipsilateral arm following radical mastectomy for carcinoma of the breast. After a variable interval, a highly malignant tumor develops in the skin of the arm, usually around the antecubital fossa. This is often first noticed by the patient as a bruise. Later a number of nodules appear which may become confluent. These nodules then undergo ulceration and necrosis followed by healing and new tumor formation. Once initiated, the course is stormy; and unless amputation is performed, the tumor rapidly extends locally and metastasizes via the blood stream. Death usually occurs from pulmonary metastases.

CASE REPORT

A 61-year-old white woman was first seen at the hospital in October 1955 for evaluation of a nodule in her left breast. A subsequent biopsy revealed infiltrating lobular carcinoma, and left radical mastectomy was done. Axillary lymph nodes were not involved with tumor. Following surgery she received deep x-ray therapy to the left supraclavicular fossa, the left axilla, left direct axilla, and left internal mammary areas. She was treated until November 1955 and received 1800 roentgens, measured in air, to each of these fields. She apparently also developed a thrombophlebitis in the veins of the left antecubital area and was given x-ray therapy to this region (400 roentgens). In October 1959, therapy was started to the left side of the chest, cross firing a recent lymph node excision site. However, the biopsy indicated that this was a nonmalignant node and treatment was discontinued after only 600 roentgens, air dose, had been given. She apparently was well until January 1965, when she noticed gradual swelling of the left upper extremity. This was later followed by the appearance of purplish-blue areas of discoloration and ulceration of the left arm. A plastic repair for ulceration was done in June 1965. The swelling progressed, and more areas of ulceration and ecchymosis of the skin appeared. Shortly thereafter a number of nodules developed in the upper arm.

She was readmitted in November 1965, and physical examination revealed a severely edematous left upper extremity showing multiple bluish patches of skin and tumor nodules extending to the left anterior side of the chest wall. A well healed, postmastectomy scar on the left side was noted. Physical examination, including the right breast and the other extremities, was otherwise unremarkable.

A fore-quarter amputation of the left shoulder was done. In April 1966, she presented with a tender subcutaneous tumor nodule on the posterior aspect of the right shoulder, and x-ray examination revealed multiple, bilateral, pulmonary metastatic lesions. Cobalt therapy to the mass over the right scapula was given in July 1966. The field (9 x 9 cm) was treated with a cobalt beam at SSD of 80 cm. A total dose of 3000 rads was given, calculated at 5 cm depth on the central axis. She also was given sarcolysine (Alkeran) orally in May 1966, and actinomycin-D intermittently for metastatic lesions, but the response was only temporary. In October 1966 she was admitted because of vaginal bleeding of one week's duration, and dilatation and curettage revealed an endocervical polyp. The patient then developed clinical evidence of intracranial metastases, became confused, comatose, and died. Permission for autopsy was refused.

The surgical specimen consisted of a fore-quarter amputation of the left shoulder (Fig 1). The arm was edematous. The skin of the entire forearm and

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Fig. 1—Amputation specimen of left arm showing discrete and confluent tumor nodules, areas of purplish-blue discoloration, and edema of the skin.

Fig. 2—The same as Fig. 1, showing nodules of the tumor with ulceration and hemorrhage. The surrounding skin is edematous and ecchymotic.

upper arm showed multiple, large, purplish-blue areas of discoloration. There were multiple, ulcerated, nodular masses noted in the upper arm, especially on the medial aspect (Fig 2). The largest of these masses was 4 x 2.5 x 0.5 cm. Portions of the skin not involved by the ecchymotic process appeared yellow. The blood vessels in the upper arm were dissected and grossly appeared normal. No tumors were noted on the hand and the digits.

Multiple microscopic sections (Figs 3 and 4)

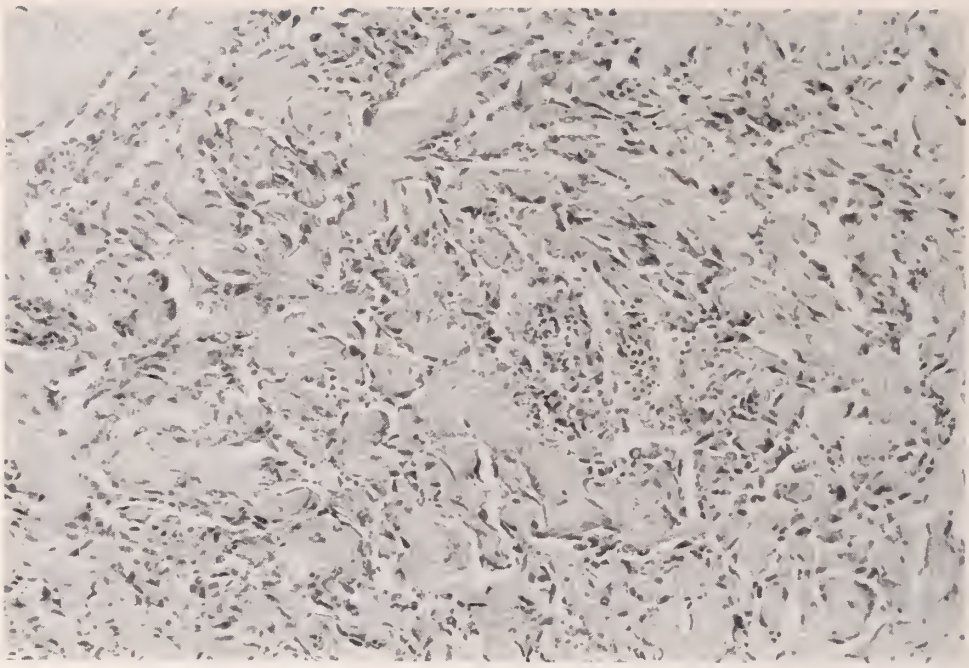

Fig. 3—Section of tumor showing dilated lymphatic spaces lined by neoplastic endothelium (150X).

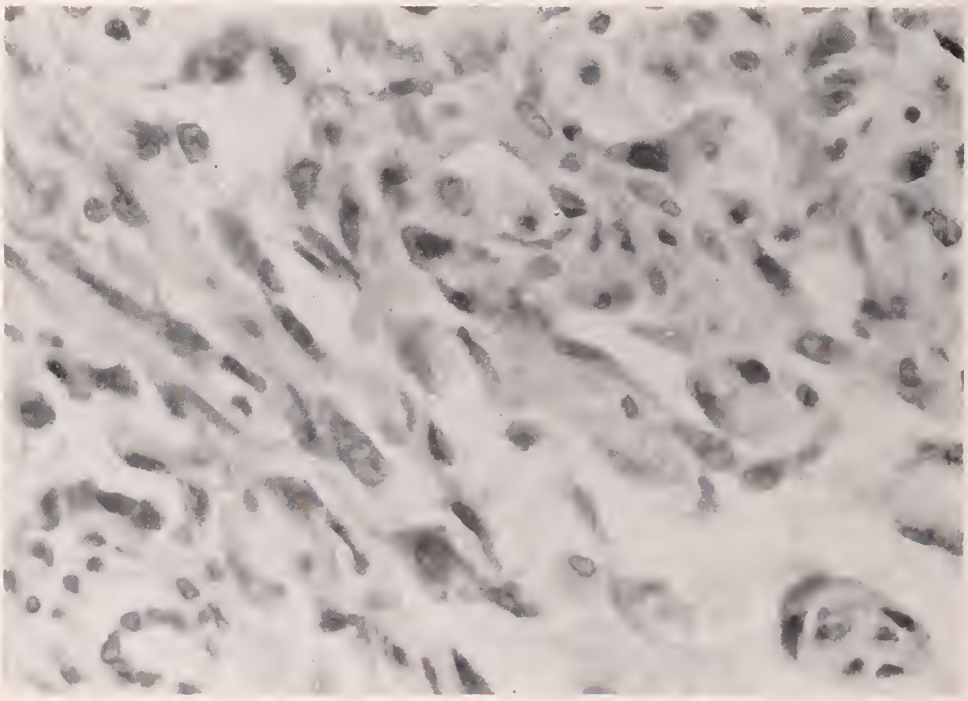

Fig. 4—Section showing bizarre neoplastic cells and chronic inflammatory exudate (600X).

through nodules of tumor showed massive invasion of subcutaneous and underlying tissue by spindle-shaped tumor cells. These cells were arranged in a cleft-like pattern forming multiple inter-connecting spaces. In some areas, the cells were arranged in a more haphazard fashion, forming small fasicle-like structures. The skin was necrotic in some areas; tumor cells formed clefts around some of the blood vessels. Sections of the major blood vessels of the arm were unremarkable. In many sections, the skin and subcutaneous tissue contained extensive hemorrhage, and the connective tissue and muscle fibers showed early degenerative changes. Sections of nerve were unremarkable.

DISCUSSION

Following radical mastectomy, a moderate amount of fat necrosis develops at the upper angle of the mastectomy scar. This later undergoes fibrosis which extends to and compresses the perivascular deep lymphatic trunks from the arm which drain into the axillary lymph channels. Axillary lymph node dissection, likewise, interferes with the lymphatic drainage of the arm.[1]

Taswell et al,[3] in an excellent review of 58 cases of lymphangiosarcoma, associated with postmastectomy lymphedema, report the average age of the patients as 62 years. Only one patient had proved recurrence of metastases from the primary carcinoma of the breast. Chronic postoperative edema was present for an average of nine years (the shortest, 16 months and the longest, 24 years) before the neoplasm was first recognized on the arm.

N. Treves[6] in 1957 extensively reviewed the etiological factors of lymphedema following radical mastectomy and found swelling of the arm in 41% of the operable cases of carcinoma of the breast. The onset of lymphedema following surgery was variable (1 to 28 months in a review of 319 cases).

No definite relationship was observed between the severity of lymphedema and its time of onset after surgery. Five of the 47 cases reviewed by Taswell et al,[3] were relatively free of edema for many years prior to the development of lymphangiosarcoma.

According to N. Treves,[6] a number of factors acting in various combinations are responsible for the production of a swollen arm following radical mastectomy. The important factors include a band of fibrosis extending from the upper angle of the mastectomy scar with compression of the lymphatics in the vicinity of the axillary veins, postoperative infection of the wound with formation of cicatrix, and preoperative radiation producing fibrosis. All of these changes directly interfere with the return of lymph from the upper extremity. Other factors, such as angulation of the axillary vein and axillary venospasm, not only compress the lymphatics in the wall of the vein but also interfere with the venous return, thereby increasing the filtration pressure. Obesity is another important factor associated with an increased frequency of development of a swollen arm following surgery.

Herrmann and Gruhn[7] stated that chronic lymphatic obstruction is an important, but not necessarily an essential, etiological factor in the development of lymphangiosarcoma. In four of the cases reviewed by these authors (including one of their own), lymphedema was transient or absent. In one of their own cases, lymphedema was not present previously and developed only after the lymphangiosarcoma was observed, possibly the result of venous and lymphatic obstruction by the tumor.

Stewart and Treves[1] postulated the existence of a systemic carcinogen responsible for the primary breast tumor as well as the lymphangiosarcoma. Occasionally they observed a third primary malignancy in the same individual. Cases have been reported, however, in which lymphangiosarcoma was the only primary tumor observed. Martorell[8] in 1956 reported a case of lymphangiosarcoma arising in a chronic lymphedematous lower extremity following fracture of the thigh. The patient was treated with osteosynthesis. The site later became infected and scar formation resulted. There was no preceding history of neoplasm.

Francis et al,[9] in 1960, described a case of lymphangiosarcoma arising in a chronically lymphedematous lower extremity. The patient had repeated pathologic fracture of the femur due to fibrosarcoma involving the upper end of the femur. The patient had previously been diagnosed and treated for carcinoma of the cervix. Five years after the pathologic fracture of the femur, the patient developed lymphangiosarcoma in the soft tissues of the thigh.

McConnell and Haslam[10] postulated atrophy and degeneration of collagen and fat in cases of long-standing lymphedema as a possible exciting factor for malignancy. They divided the lesions into a premalignant and malignant phase. This view was supported by case reports of Bowers et al,[11] in which the lesion was shown to pass from an apparently benign to a malignant stage.

In the past, the lesion has undoubtedly been unrecognized or misdiagnosed as skin metastases from carcinoma of the breast or as Kaposi's sarcoma. As pointed out by Stewart and Treves,[1] the lesions of lymphangiosarcoma tend to spread more to the periphery, while those of recurrent breast tumor tend to spread toward a central point.

Moreover, it is most unusual for secondary breast carcinoma to appear in the skin of the arm of the patients who have survived five years or more. Also, the lesion presents distinctive histologic features. Kaposi's sarcoma usually occurs in males and is often symmetrical, involving the legs. Edema of the extremities usually follows, rather than precedes, the onset of this type of tumor. The microscopic picture presents primarily proliferating blood vascular channels rather than lymphatics. Another similar lesion,[5] malignant hemangio-endothelioma, should also be considered in the differential diagnosis. Although blood vascular proliferation and areas of hemorrhage occur in lymphangiosarcoma, the lesion is primarily a proliferation of lymphatics. Moreover, malignant hemangio-endothelioma is an uncommon neoplasm which usually arises in viscera or deep soft tissues rather than in the skin or subcutaneous tissues. Lymphangiosarcoma also should be differentiated from amelanotic melanoma which, however, has distinct histologic differences.

Stewart and Treves[1] regarded the tumor to be resistent to irradiation and, therefore, recommended interscapulothoracic amputation. All of their patients, however, died of pulmonary metastases. Chu et al,[12] reviewed 50 cases and found only three who survived five years or more after treatment. One of these was treated with fore-quarter amputation; the second, by fore-quarter amputation followed in less than a year by local excision of recurrent tumor; and the third, by radiotherapy. According to these authors, irradiation offers good palliation. The tumor shows good regression, although the response is only temporary. Khodadadeh et al,[4] reviewed the treatment of 76 cases and found 5 of 25 patients treated with interscapulothoracic amputation to be alive and well 1 to 11 years postoperatively. The remaining patients in this group died in less than three and one-half years. Eighteen patients were treated with irradiation alone —two were alive 2 to 12 years following treatment, and the remaining died in less than four years. Wide local excision of lesion with irradiation was done on 13 patients; all died in less than four and one-half years. Disarticulation of the arm was performed on 10. Only one survived and was well 51 months postoperatively. The remaining died in less than two years. No specific treatment was given to 10 patients, and all these died in less than one year.

SUMMARY

A case of postmastectomy lymphangiosarcoma with a brief review of the literature is presented. Important plausible etiological factors in the pathogenesis of this lesion are discussed. Prognosis in most patients is grave. Only a few survivors are known. Radiotherapy, interscapulothoracic amputation, and local excisions have been tried in various combinations without encouraging results.

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Lower Lip Reconstruction for Carcinoma

By GEORGE J. KORKOS, M.D., Milwaukee, Wisconsin

■ SQUAMOUS CELL CARCINOMA of the lower lip is generally considered one of the most favorable cancers of the oral mucosa for the following reasons.[1]

(1) Early detection on the part of the patient.
(2) These lesions lie dormant for a long period of time before penetrating deep to the orbicularis oris muscle.
(3) Only 6% to 10% of these lesions metastasize to regional lymph nodes.
(4) Excellent resectability by the surgeon, because of good operative exposure.

This disease most commonly occurs in persons 40 to 80 years old, and especially in the sixth decade of life. It is found almost exclusively in males who have significant history of pipe or cigarette smoking. Other etiologic agents are trauma, leukoplakia, which is known to be precancerous, and any acute inflammatory reaction, which may stimulate the activity of a precancerous or cancerous lesion. Irradiation and actinic rays of sun have also been implicated in the etiology of carcinoma of the lip.

Any firm or hard lesion of more than three weeks duration, which has not healed, should be viewed with some suspicion, because lip carcinoma is easy to diagnose and the lesion is readily accessible.[2]

If lip cancers, however, are not treated as soon as possible, they will metastasize eventually, first to the submaxillary triangle and then to the internal jugular chain. These lymphatics frequently course around the periostium of the mandible. In widespread disease, lip resection, anterior mandible, and radical neck dissection, en bloc, is often necessary to effect a cure. Without involvement of the internal jugular chain, bilateral suprahyoid dissection may be sufficient.[2] This latter point is often debated by many surgeons, such as Hayes Martin, who feel that suprahyoid dissections are inadequate and that radical dissection is the procedure of choice, if indeed a neck dissection is indicated.

Without node involvement, most authors prefer adequate resection of the primary lesion only, since in 89% there is a five-year-survival cure rate. Hayes Martin does not

CASE 1—V-excision of lip

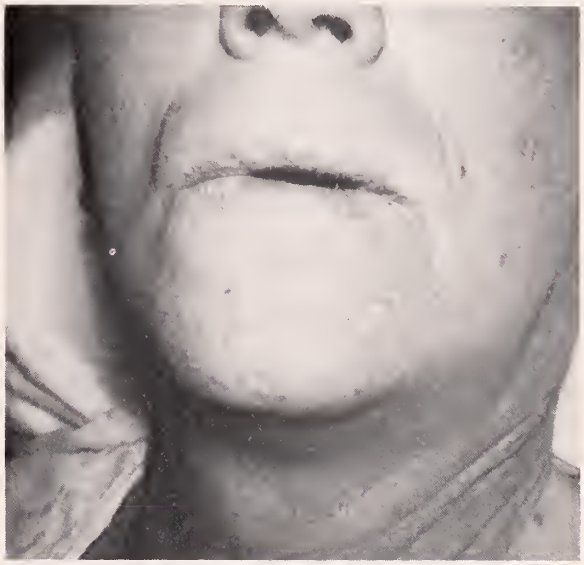

Fig. 1a—Preoperative: lower lip carcinoma, left side.

Fig. 1b—Postoperative resection: three-layer closure —labial mucosa, muscle, and skin.

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CASE 2—V-excision and lip shave incontinuity

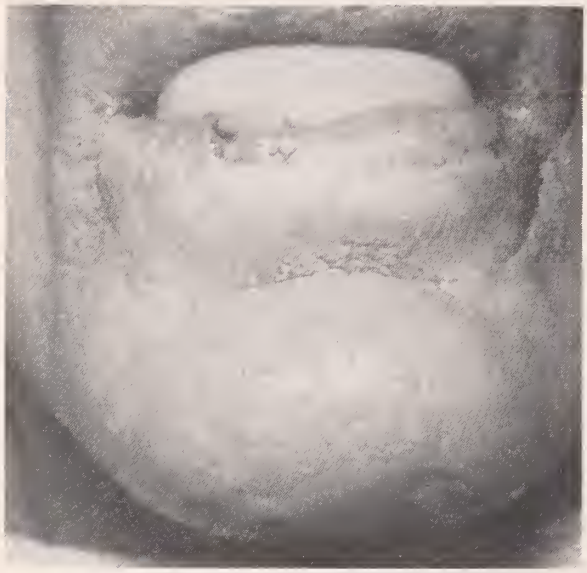

Fig. 2a—Preoperative carcinoma.

Fig. 2b—Excision.

Fig. 2c—Specimen.

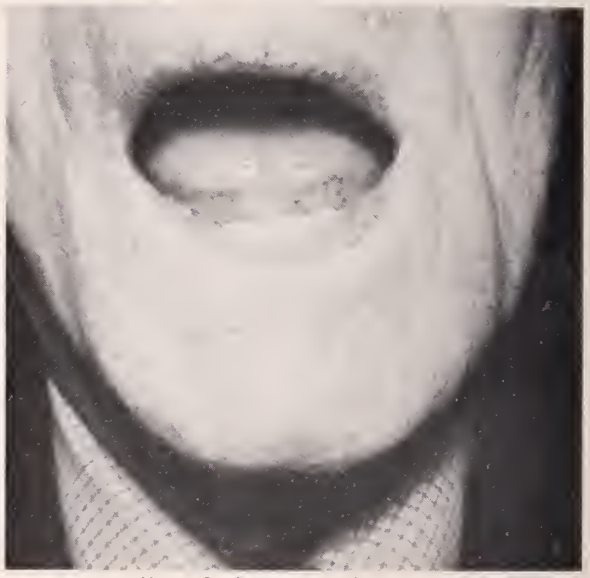

Fig. 2d—Postoperative status.

perform a neck dissection for lip cancer, stating that only 8% developed metastasis with control of the primary lesion, so in 92% of the cases, radical neck dissection would have been of no value. Edgerton and DeVito make a plea for the abandonment of the term "prophylactic" neck dissection for such procedures are dependent on the location, grading, and stage to which the lesion has progressed. Radical neck dissection should, therefore, not be routine, but each case must be evaluated on its own merits.[3]

Satisfactory results in the treatment of cancer of the lip have been obtained by radiation therapy. Control of the primary lesion was obtained in 73% of cases.[4] Paletta states that surgical intervention is preferred over irradiation because surgical removal of the entire vermilion border for leukoplakia of the lower lip had been emphasized in which 12% of the lesions clinically diagnosed as leukoplakia were actually carcinoma in situ.[5] Similarly, it is advisable to extend the V-excision for carcinoma of the lip to include a lip shave of the remaining vermilion border. This will then prevent the development of a second neoplastic lesion, since frequently the remaining vermilion shows some

Fig. 3a—Preoperative lower lip carcinoma.

Fig. 3b—Excision and Estlander flap.

Fig. 3c—Secondary commissurotomy.

evidence of leukoplakia and may contain another focus of neoplasia. Since leukoplakia is usually not treated by irradiation, other foci of neoplasia will be missed when carcinoma of the lip is irradiated. In case 2 (Figs 2a, b, c, d), the primary lesion had a deep componant so that a V-excision was necessary. Along the lower lip vermilion there were also two very small denuded areas and a lip shave in continuity with the V-excision was performed. The lip shave revealed an additional two carcinomas in situ, which were resected along with the lip shave.

Many methods have been brought forth for the resection of cancer of the lip. Small lesions measuring less than 1 cm and having a deep componant, which after obtaining an adequate margin does not involve one-third of the lower lip, may be excised as a wedge excision with primary closure. This procedure was performed in case 1 (Figs 1a, b). The V-excision had a border of 4 mm on each side, with thru and thru excision of the labial mucosa, orbicularis oris muscle, and skin. The lip reconstruction was performed in three layers, closing individually the mucosa, muscle, and skin.

If carcinoma of the lower lip is superficial, has no deep componant, and the texture of the remaining lip is suspicious, a lip shave or vermilionectomy is the procedure of choice.

The repair of larger defects necessitates flap reconstruction and rotation. A better cosmetic result can be obtained if locally adjacent tissues are available rather than bringing in flaps from a distance. The latter are often bulky, anesthetic, require many more procedures, and are of poor color match.

The concept of repairing a lip defect using a vermilion bordered flap was first described by Sabattini of Italy in 1838. Ten years later, Stein of Denmark, rotated two small laterally based midline flaps downward, from the philtrum into the lower lip. In 1863, Gurdon Buck of New York again reported this

CASE 4—Rotation Abbe flap

Fig. 4a—Preoperative carcinoma of lower lip.

Fig. 4b—Final result: Abbe flap.

method. Estlander of Finland, in 1877, repaired lateral defects of the lower lip by rotating a flap from the upper lip and cheek, which included the commissure of the mouth. This procedure was instituted in case 3 (Figs

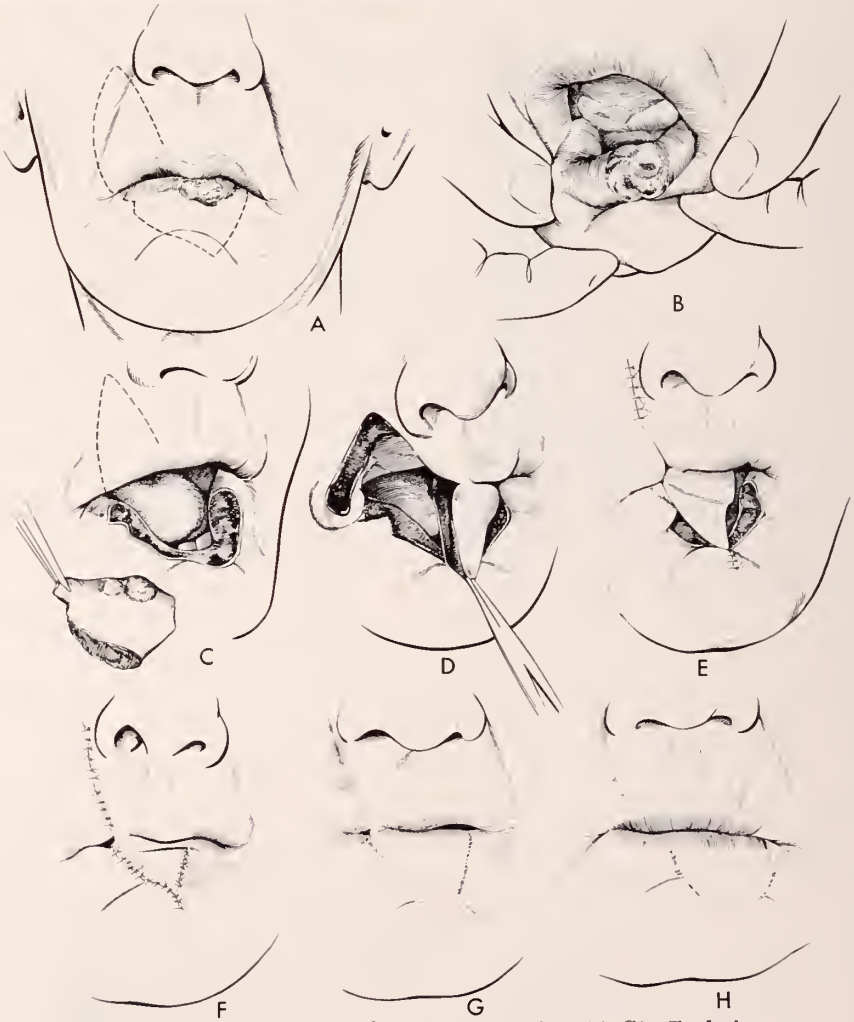

Fig. 4c—Rotation Abbe flap reconstruction (A-G). Technique: division of pedicle flap (H).

CASE 5

a *b*

1. 5a—Reveals previous lip V-excision with metastatic fullness in right submaxillary triangle.

Fig. 5b—Postoperative resection.

g. 5c—Specimen to include portion of mandible, biopsy site, and neck contents of the right side.

, b, c), because the resection of the large rcinoma, with an adequate margin, inlved approximately one-third of the lower). If this were primarily closed, the stoma ould be considerably smaller with an asymmetrical appearance. Following the rotation of the Estlander flap, to include the commissure of the mouth, it was necessary to perform a secondary commissurotomy procedure to open the left corner of the mouth, so as to obtain normal mouth opening and symmetry.

In 1898, Abbe of New York rotated a central flap from the lower lip into the upper, requiring division of the pedicle after revascularization from the recipient site had taken place. The flap is usually divided from its pedicle at approximately 18 to 21 days, and a revision of the vermilion is performed at the same time. This procedure was instituted in case 4, because the primary lesion was central in position and the large defect was readily reconstructed by an upper lip pedicle flap. Many variations of these latter two operations have been developed over the years, but the principles laid down by Abbe and Estlander are essentially the same. Examination made on the regeneration of sensory, sympathetic, and motor nerves has demonstrated a complete return of sweating with sensitivity to pain, touch, and temperature occurring within two years.

Early in the postoperative course as in all cancer surgery, the prognosis is guarded. Although it is known that squamous cell carcinoma of the lip is probably the most favorable of all oral mucous membrane cancers, because of its accessability and low rate of metastasis, the patient should be examined at regular intervals. To substantiate this point, in case 5 (Figs 5a, b, c), the patient had a V-excision for a squamous cell carcinoma of the right lower lip, and was free of metastasis for approximately three years. Examination at that time revealed a hard

CASE 6

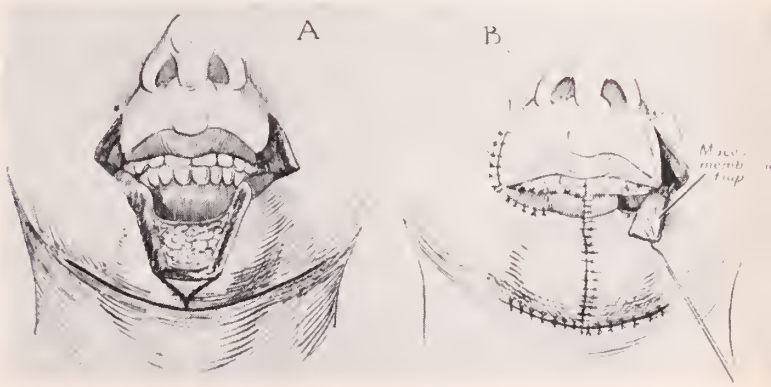

Fig. 6—Bernard procedure.

mass in the right submaxillary triangle, which appeared to be attached to the inferior border of the mandible. This tumor mass in the right submaxillary triangle was excised at the time of surgery and frozen section revealed metastatic squamous cell carcinoma, and a standard neck dissection was performed to include a circumferential area of the skin biopsy site.

Because of the continuity of the metastatic node to the mandible, a portion of the mandible also had to be resected en bloc. Microscopic sections of the specimen revealed three positive nodes above the omohyoid, the remaining nodes below the omohyoid being negative for tumor cells. This point is quite inherent in metastasis of carcinoma of the lower lip, in that it appeared to metastasize to the submaxillary triangle and lie dormant for a number of years before extending into the internal jugular chain area.

As was noted in cases 3 (Figs 3a, b, c) and 4, lip reconstruction by the immediate use of the adjacent flaps, is easily accomplished in older people with loose cheeks. This procedure can be carried out at the same time that the tumor is resected. As a result, the patients' social, emotional, and economic well being are not so profoundly disturbed.

Another procedure which is used in the repair of extensive loss of the lower lip is the Bernard operation (Case 6, Fig 6). La lateral base sliding flaps are developed lowing the excision with division of the s of the chin down the midline and tra versely beneath the mandible. Sliding of flaps is facilitated by excision of two Bu triangles in the inferior ends of the na labial folds, but preserving the underly mucosa to reconstruct the vermilion. E sion of the triangles prevents pouching the upper lip and microstomia.

In 1964, Andrews[6] presented the repai lower lip defects by use of the Haged rectangular flap method, which is an orig repair for congenital cleft lips in childr In 1955, Ashley[7] also described local flap p cedures for repair of defects of the lo lip following cancer operations (Case Fig 7).

Flaps from the cervical area as well the nasal labial fold, either single or bilate flaps, also have been used in reconstruct of the lower lip. These procedures may h to be instituted when there is complete s rifice of the lower lip. The main disadvant is that numerous procedures must be p formed for revision and defatting of th flaps.

CASE 7

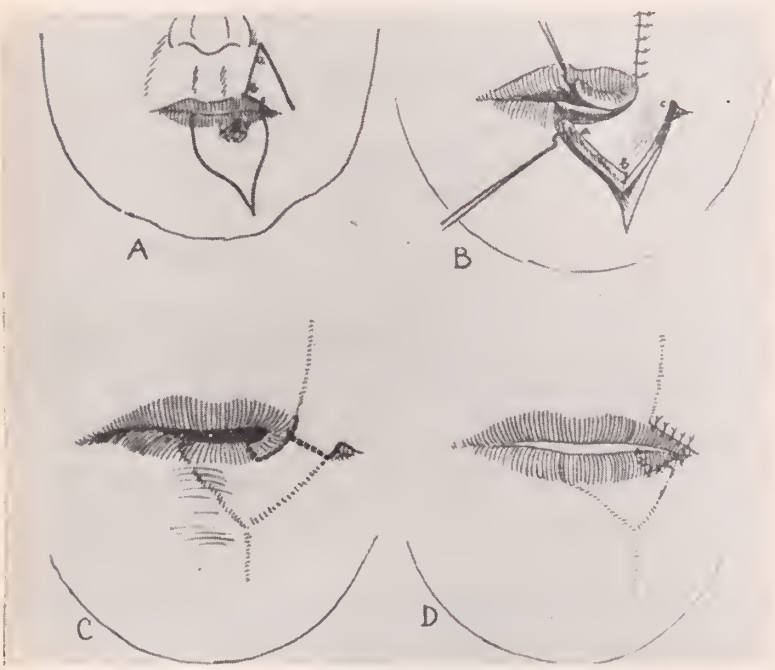

Fig. 7—Ashley procedure.

SUMMARY

Cases of squamous cell carcinoma of lip were presented in various forms and lo reconstruction procedures were dem strated. The success of cancer surgery directly proportional to the vary care follow-up. It is known that carcinoma of lip metastasizes in 6% to 10% of cases the regional lymph nodes; however, rar does it extend beyond the clavicles. The fore, careful examinations at regular int vals would detect early metastasis at wh time a survival rate of 40% can still obtained.

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Current Therapy—Transplantation
(Modern Day Saints Cosmas and Damian)

By ROBERT C. HICKEY, M.D.
Madison, Wisconsin

MANY MODERN SCIENTIFIC accomplishments have deep roots. Leonardo da Vinci espoused air transportation, and homotransplantation was reported first from the Garden of Eden on the occasion of a rib transfer.

Next in the field of transplantation were the Brother Saints, Cosmas and Damian. In legend Cosmas and Damian were Arabian, likely twins, who practiced medicine in Asia Minor; they carried out their good works in the third century and were beheaded, presumably in September in the year 287 A.D., because of their devotion to Christendom.

In the fifteenth century, under the sponsorship of one of the Medici, considerable artistic attention was directed to feats credited to the Saints Cosmas and Damian, and numerous descriptive canvases are in the major galleries of Europe, particularly of the miraculous cross exchange of a diseased limb for a good one centuries after the beheading.

The patient involved had devoted himself to the service of the Holy Martyrs of the Church of Saints Cosmas and Damian in Rome. As he slept, the saintly brothers appeared to him in a dream carrying various drugs and instruments. One brother went to the Cemetery of St. Paul-in-Chains and removed the extremity from a "Black Moor" who had been buried the previous day; upon returning, they amputated the patient's leg, and attached the leg from the corpse to the stump. The diseased extremity was placed in the tomb with the Ethiopian, and on the following morning their patient was overjoyed to discover that he had a healthy extremity, without pain. When he related his story, the tomb was opened and the diseased extremity was found contained therein.

The author has seen this scene depicted by Fra Angelico in the Museo de' San Marco, Florence; by an unidentified artist in the Museum of the Alhambra, Granada, Spain; and by Fernando Rincon in the Prado, Madrid. We are able to reproduce the latter

Doctor Hickey is Professor and Chairman, Department of Surgery, University of Wisconsin Medical School.

COMMENTS ON TREATMENT

Presented through the cooperation of the Department of Pharmacology, Marquette University, Milwaukee, and the Department of Medicine, University of Wisconsin, Madison

HAROLD F. HARDMAN, M.D., Ph.D., Co-Editor
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Painting by Fernando Rincon
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Homotransplantation of human tissues is truly a part of modern medical center therapy. The special instances, as split thickness skin for temporary coverage after thermal injury, corneal grafting, and blood transfusion are almost commonplace. The modern transplant saints are exemplified in the personage of the clinician and his basic scientist counterpart. One cannot identify which is Cosmas and which Damian.

In the past 30 years renal transplantation has been a challenge. The Peter Bent Brigham Hospital group has been able to analyze 120 patients who had transplants between 1951 and 1966. With immunosuppressive drugs, corticoids, and patient-matching techniques, this area, supported by renal dialysis, presents a real opportunity. The University of Wisconsin Medical School is well launched on a renal transplant program* and so also shortly will be Marquette University Medical School.

In another area during the past decade there has been a striking risk reduction for patients subjected to aortic valvular corrective surgery as a consequence of improved valve prosthesis, better surgery, the postoperative care, and patient selection. A considerable boon to aortic valvular surgery will likely be the homotransfer of aortic valvular tissue, as suggested by the experience to date of Wisconsin's Dr. William P. Young. Among other diseases, for example, the child with biliary atresia, one can envision transplantation as the only hope.

The miracle of Saints Cosmas and Damian will not come to every day fruition immediately. There may be many more trips to the Church of St. Paul-in-Chains, figuratively, the basic science laboratory, but for some diseases and conditions, there seems no other path.

* See the September issue of the JOURNAL for article "Kidney Transplantation Program at the University of Wisconsin Medical Center" at page 442.

WISCONSIN'S HEALTH

by E. H. JORRIS, M.D., State Health Officer

OCCUPATIONAL HEALTH NURSE HELPS WORKERS STAY WELL

Here in Wisconsin two state agencies are deeply concerned with the health and safety of people employed by industrial and commercial establishments. They are the Division of Health, Department of Health and Social Services and the Department of Industry, Labor and Human Relations.

Within the Division of Health the Section of Occupational Health has a staff which devotes full time to assisting industry and labor in the evaluation and control of health hazards in the working environment and in the establishment and improvement of employee health programs.

A key figure in safeguarding the health of our state's workers is the occupational health nurse. There are 550 RNs employed as occupational nurses in more than 300 industrial establishments throughout Wisconsin. In addition to manufacturing plants, many hospitals, insurance companies, banks, and other enterprises have a nurse assigned exclusively to employee health. Working with this group is a nursing consultant of our Section of Occupational Health.

The primary goal of an employee health program is to "help workers help themselves to stay well." The nurse's functions range from planning for and providing emergency care for injured and ill employees to working with the physician-in-charge in developing health promotion and health maintenance programs. Traditionally, she has been looked to as a source of help and support when health problems arise.

Because many people in Wisconsin are reached daily by nurses working in the occupational setting, the Division of Health makes every effort to inform these nurses of current health matters and of community health resources, so that they, in turn, can offer the best possible service to employees. For example, materials covering suggested immunization procedures, child safety, the need for continued use of iodized salt by Wisconsin residents, recommendations on tuberculosis testing, and an up-to-date listing of public health nursing services in the state were sent recently to the occupational health nurses.

Last year the Section of Occupational Health worked with the State Medical Society of Wisconsin and other groups in producing and distributing a newly-revised "Occupational Health Guide for Medical and Nursing Personnel," which is being widely used by physicians and nurses in our state.

Helping to keep Wisconsin's working population "healthy and productive" is the concern of many. Among them the Division of Health is carrying out programs aimed at the elimination of health hazards in the working environment and the promotion of the total health of workers and their families.

THE PRESIDENT'S PAGE

HAROLD J. KIEF, M.D.

SMS means aggressive leadership

"Our Girls Friday"

■ IN OCTOBER 1955, a movement began which was destined to have an ever increasing influence on the quality of care in physicians' offices throughout the United States. One year later in Milwaukee, Wisconsin, many young ladies banded together to form the American Association of Medical Assistants. This organization has now grown so that there are chapters in all 50 states, with thousands of participating members.

Their objectives are: to inspire its members to render honest, loyal, and more efficient service to the profession and to the public; to strive at all times to cooperate with the medical profession, and to render educational service for the self-improvement of its members.

In the state of Wisconsin we have a very active Medical Assistants Society (WSMAS)—a society of over 500 dedicated women who are devoting their energies and knowledge to help you, the practicing physician.

However, a membership of 500 or more is not enough for a state as large as ours—a state with over 4,000 doctors. There are many counties in Wisconsin with no WSMAS group. This is where the physicians can be of help. Investigate this fine organization and encourage your medical assistants to join. This means both your laboratory and administrative assistants (secretaries, bookkeepers, nurses, receptionists).

This, Doctors, is NOT a union. This is NOT an association formed to discuss or impose salary schedules or fringe benefits. But it is an association to help us give better patient care. This association is recognized by both the American Medical Association and your own State Medical Society and functions under their guidance.

These aggressive girls have shown their enthusiasm to help us and themselves by instituting frequent seminars devoted to such topics as psychology, communications, bookkeeping, and new federal laws, just to mention a few. Under their aegis, courses are now given in recognized vocational schools in Milwaukee, Green Bay, and La Crosse, leading to certification as a medical assistant.

Furthermore, in 1961 the American Association of Medical Assistants established a Certifying Board to administer an annual examination covering the administrative and clinical responsibilities of medical assistants. Satisfactory completion is recognized with presentation of a certificate and the right to wear the coveted CMA pin.

The examination is a two-day written test given on the campuses of cooperating colleges throughout the United States on the last Friday and Saturday in June. Any medical assistant who is a high school graduate or equivalent, who has a minimum total of three years employment by a Doctor of Medicine in an office, hospital or clinic, and who is employed by a physician member of the American Medical Association may apply for an examination.

Yes, these are but a few of the educational aspects of this great organization, an organization composed of "our girls." These girls are sincere, dedicated women who want to be of greater service to us, to our patients, and to medicine. It supplants, but does not replace, any of the other paramedical groups, such as nurses and medical technologists.

When your office assistant tells you she would like to join WSMAS, remember it is in your best interests, both professionally and business-wise, to encourage her. Help her with the expenses of attending meetings for this represents an investment in improved office management.

If you, Doctor, are asked to speak before a meeting of a local chapter, you'll be doing your profession a favor if you accept. I have, and I always will be glad to help "Our Girls Friday."

H J Kief MD

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EDITORIALS

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GUEST EDITORIAL

Time for Reassessment

■ AFTER EXPERIENCE of a little more than a year with Medicare, perhaps it is time to pause and look over the situation. One conclusion is that it is not all bad. In spite of its socialistic ingredient of providing benefits because the recipient reaches his 65th birthday, we can recall many golden agers who would have been hard put financially to pay for medical and hospital expenses provided now by Medicare.

In retrospect, Medicare was conceived by the social planners, and, after a moreorless shotgun wedding with the legislators, it was brought to term without the help of the Medical Profession. This resulted in the birth of the baby we know as Medicare—of somewhat questionable legitimacy.

However, the baby was born. It was only then that the bewildered and apprehensive parents called for the help of the Medical Profession. We furnished what I will call "political pediatricians." They did a good job, handicapped as they were by a baby who had no medical prenatal supervision.

What am I getting at? Simply this: perhaps it is time for us and for our leaders to change our traditional policy of opposition to one of participation. There are many of us who have revised our thinking to the point of realizing two things. One is that government, whether it be local, state or federal, has a legitimate part in certain aspects of health care of the people. The other is that future health legislation is inevitable. It seems to me that Medicine has a duty and a moral obligation to participate in the formulation of future health legislation, always striving to keep it within the framework of legitimate government activity.

Undoubtedly, all members of the Medical Profession will not agree with these premises, but for those of us who do, what is our best course of action? As Doctor Blasingame pointed out in a recent talk at an AMPAC meeting in Washington, D.C., we already have many effective means of action. We have AMPAC itself which can be powerful if it is actively supported by all members of our profession. We have a skilled and intelligent lobby which helps us immensely. We have publicity campaigns and letter writ-

ing campaigns which are of inestimable value at the proper time. These are all essential parts of sound political activity, but there is still one vital ingredient lacking.

We, as a profession, need to take part in the planning of future health legislation. In other words, we must have political obstetricians as well as political pediatricians. I am certain that the AMA from its vast reservoir of medical talent can produce these men.

With the goal of better health for all our people, let us concentrate on the problems ahead. What is past is past. Let us now concentrate on the future. Let us work for better health legislation for the good of all the people, preserving the free enterprise philosophy that made our nation great.

Let us have our lobby, our AMPAC, our publicity and letter writing campaigns, our pediatricians, but by all means, let us also have our obstetricians to insure expert medical guidance during the prenatal days of all new health legislation.—JOHN H. HOUGHTON, M.D., Wisconsin Dells

GUEST EDITORIAL

Presidential Invitation

IT IS WITH GREAT pleasure that I invite you to my home state this fall, to the AMA Clinical Convention at Houston, November 26–29.

I believe you will find the convention's program particularly interesting; it offers refreshing insights into clinical problems that you will find useful in your practice or professional duties.

This meeting is especially designed to help us keep up-to-date on latest medical developments. For the 21st consecutive year, the AMA has assembled an extensive, well-rounded program outlining current knowledge.

You will be impressed, I think, by the outstanding medical teachers who have accepted the invitation of the Harris County Medical Society and the AMA Council on Scientific Assembly to participate in the scientific program. The Harris County Society has done a fine job in bringing together this program.

For you, the Clinical Convention presents opportunities for refreshing your medical knowledge, for renewing associations with fellow physicians, and for catching a breather from your busy schedule. It promises to be a stimulating four days, worthy of your time.

With my colleagues, the physicians of Texas and Harris County, I cordially invite you to Houston, a dynamic, interesting city that you and your family will enjoy.

See you at the Clinical!—MILFORD O. ROUSE, M.D., *President*, American Medical Association

Reduction of Error

RECENT ARTICLES in the medical press have indicated a growing awareness on the part of doctors that the ancillary services available to them are somewhat less than error-free. Unreliable laboratory reports was the subject of testimony by Dr. David J. Sencer, director of the National Communicable Disease Center, before a Senate subcommittee earlier this year. Closer to home, a random inspection of a "quality control program" report by the State Laboratory of Hygiene, listing test results of prepared glucose standards by approximately forty participating Wisconsin laboratories, disclosed a disturbing amount of error.

As our population grows and health care becomes open to more people, the personnel of hospitals and independent laboratories grows apace. It is not strange that with the substantial increase in the number of people there should be room for a greater number of errors. In addition, with the physical growth of medical centers and the attempt to promote administrative efficiency, a certain lack of personal consideration is certain to appear.

In this context the doctor is the key figure. Since the responsibility for the patient's welfare is his, he must insist on a continuously high quality of performance on the part of all the clinical and laboratory workers upon whom he depends. As far as laboratory testing is concerned, it appears that the difference between good work and poor work is a matter of good personnel and adequate

quality control mechanisms. As Doctor Sencer pointed out, almost anybody, regardless of training or experience, can operate or direct a clinical laboratory except in a few states. Some kind of licensure seems to be indicated to insure that such laboratories are able to produce reasonably accurate results.

Outside of the laboratory the physician must be constantly vigilant to see that his instructions are carried out to the letter, regardless of inconvenience to the hospital staff. He must personally see that equipment is functioning properly and that it is being used correctly, and that his patients promptly receive the treatment he expects to be given.

As health care activity grows, doctors must learn to depend less on ancillary personnel. The answer is double-checking, constant verification, and continual insistence on accurate performance. The figure of a martinet is not one regarded with warmth by hospital and laboratory employees, but with the patient's welfare at stake, a doctor can't afford to try to win popularity contests with the nurses and lab technicians.—DNG

Advertising Restraints

WHEN THE FOOD and Drug Administration asked for comment on its proposed new regulations for labeling and advertising drugs prescribed by physicians, withering blasts from representatives and friends of the pharmaceutical industry were not long in coming. Some critics of the FDA charged that the regulations, by assuming the physician's inability to make valid individual judgments about drugs, interfered with practice rights and responsibilities conferred by his license.

Broadly speaking the proposed regulations would compel the advertiser of a prescription drug to tell the full story in all of his advertising. If an advertiser suggests the use of his product he must also list in specific detail all of the side effects and contraindications. Allegations as to what a drug will or will not do are spelled out—for example, advertising for an antibacterial drug must name the types of infection as well as the microorganisms for which the drug is clinically effective.

Apparently the FDA's proposed new regulations go so far as to specify how much space should be given to the negative aspects, in terms of the space and prominence given to the positive allegations contained in the ad. They take into consideration such purely technical matters as layout, typography, graphic design, and the like. They go farther than any comparable limitations imposed on other advertisers although the FDA's brother bureau, the Federal Trade Commission, is not far behind with an impressive panoply of so-called consumerist-oriented limitations on advertisers.

But unpleasant as these proposed regulations are to contemplate by the advertiser, the opponents are over-reacting when they claim that they abridge any right of the physician that his license confers upon him. It is certainly no interference with a physician's practice when the FDA insists that full information about any product he prescribes be available to him and that he be made aware of the possible dangers involved in the use of any new product. The license to practice does not confer omniscience, and doctors have every right to expect that ethical advertisers of ethical pharmaceuticals will furnish both positive and negative information about their products. Most do so already. These high standards would now be spelled out in greater detail and extended to sales promotion appearing elsewhere than in journals.

Physicians should welcome the proposed new regulations, especially in view of the proliferation of new drug products. Advertising is an important source of information for doctors, and it must be admitted that pharmaceutical ads are appealing and convincing. Considering the possible serious consequences of improper use of prescription drugs, it is only right that the sales promotion of these products be subject to the highest possible standards and that such standards be enforced uniformly.—DNG

SUPPORT YOUR FOUNDATION

It is your opportunity to give financial assistance to the charitable, educational and scientific aspects of medicine as they relate to the health and well-being of the people of Wisconsin. All contributions to the Foundation are deductible for income tax purposes. Checks may be made out to: CES Foundation, and sent to CES Foundation, State Medical Society of Wisconsin, Box 1109, Madison, Wis. 53701.

LETTERS

EXPRESSION OF THANKS

To the EDITOR:

To say I was profoundly moved by the honor given to Dr. Beckman and me by the State Medical Society of Wisconsin expresses quite inadequately my emotional response. To be honored by one's peers is a most satisfying experience. I have, however, one criticism to offer and that is in regard to the timing of the Festschrift. Such an event is usually reserved for the end of a career. As to Dr. Beckman, I see no sign of any slackening in his productive activities, and I find myself innocently the contributor of an original article to our own Festschrift.

When literally showered with glory and called famous, one is compelled to speak in self-defense. Fame is an elusive attribute that depends far more on luck than on sheer ability. Few have the good fortune of having the right type of mold fall into their Petri dish. My mold was the one-stage prothrombin time. Marquette University furnished the favorable environment for culturing the mold and fellow physicians helped me to apply clinically the product of this figurative mold.

I am most grateful to all who were responsible for the Festschrift. I thank those who contributed articles and those who wrote letters addressed to Dr. Beckman and me. I deeply appreciate the editorial of Dr. Harold J. Kief and heartily endorse his concluding paragraph.

ARMAND J. QUICK, M.D.

To the EDITOR:

To all of you who sponsored the Festschrift:

You have really warmed the cockles of an old fellow's heart. I am deeply grateful.

HARRY BECKMAN, M.D.

ROYAL SUPPORT FOR ROYAL FOUNDATION

To the EDITOR:

The enclosed release (reprinted below) is forwarded in the hope that you may publish it in the *Wisconsin Medical Journal*. The design of the Foundation is obvious—and I am completely partial in its efforts to obtain financial support from this country. My contacts with the Royal Society of Medicine have been close over the years. During World War II, the Inter-Allied Conferences on War Medicine, held under its aegis, were a splendid contribution to the total effort.

WILLIAM S. MIDDLETON, M.D.
Madison

NEW YORK—The Royal Society of Medicine Foundation, Inc., has been formed to establish closer relations between members of the medical profession in Great Britain and the United States.

The new Foundation, organized under the auspices of The Royal Society of Medicine, provides an opportunity for individuals, corporations, government agencies and charitable foundations in the U. S. to support medical research in Great Britain and to foster closer relationships between members of the medical profession in both countries.

Tax-deductible contributions to the Foundation will be used to improve facilities for medical research and education, as well as to provide medical scholarships, to sponsor conferences for the exchange of information on medical research and to preserve medical literature.

The Royal Society of Medicine is a 13,000-member organization established in London, England, in 1805 "for the cultivation and promotion of physic and surgery and of the branches of science connected with them." Today, its worldwide membership includes over 1,000 U. S. physicians.

Activities of The Royal Society of Medicine range over the whole of the clinical and part of the preclinical field. Among its principal activities is maintenance of one of the largest medical libraries (500,000 bound volumes and 3,000 current periodicals) in the world, and the most comprehensive one outside the U. S.

The Board of Directors of The Royal Society of Medicine Foundation, Inc., is comprised of eminent leaders in the fields of medicine and business in Great Britain and the U. S. They are:

Francis Boyer, President, RSM Foundation, Inc.; Director and former Board Chairman, Smith Kline & French Laboratories, Philadelphia.

Dr. Howard R. Craig, Secretary, RSM Foundation, Inc.; former Director, The New York Academy of Medicine.

William N. Creasy, Treasurer, RSM Foundation, Inc.; President, Burroughs Wellcome & Co., Inc., Tuckahoe, N. Y.

Dr. Frank E. Adair, Past President American Cancer Society; Associate Professor of Clinical Surgery, Cornell University Medical College, New York City.

Dr. William B. Castle, Former Chairman, Department of Medicine, Harvard Medical School; now on consulting staff in Internal Medicine, Boston City Hospital, Boston.

Dr. Andre F. Cournand, Awarded Nobel Prize in Medicine and Physiology in 1956; Professor Emeritus of Medicine, Columbia University College o. Physicians and Surgeons, New York City.

Dr. Derek Denny-Brown, Former J. Jackson Putnam Professor of Neurology, Harvard University; now at New England Primate Research Center, Southboro, Mass.

Dr. Robert F. Loeb, Former member, the President's Science Advisory Committee; former Trustee, the Rockefeller Foundation; Bard Professor Emeritus, Columbia University; Consultant to Presbyterian Hospital, New York City.

Sir Hector MacLennan, President, The Royal Society of Medicine.

Dr. William S. Middleton, Professor of Medicine and Dean Emeritus of the University of Wisconsin Medical School, Madison, Wis.

Milton C. Rose, Partner in the law firm of Nixon Mudge Rose Guthrie Alexande. and Mitchell; director or officer of several philanthropic organizations, New York City.

Dr. F. Peyton Rous, Awarded Nobel Prize in Medicine and Physiology in 1966; Member Emeritus, the Rockefeller Institute for Medical Research; Scientific Consultant to the Sloan-Kettering Institute for Cancer Research.

A TRIP ON THE S.S. HOPE

To The Editor:

In answer to your letter, . . . I spent 2 months on the Hope from February 15, 1967 to April 15, 1967. We worked with the medical school at the University of Cartagena in Cartagena, Colombia. About half my time was spent on the Ship which was anchored in the inner harbor of the city and the other half was at the University Hospital of Santa Clara at the University ashore.

On the ship we had 26 pediatric beds and the medical staff consisted of myself, Dr. Rocca the Colombian pediatrician, two residents, one intern and two senior medical students. We spent the mornings examining and studying the cases and going over the differential diagnostic possibilities. In the afternoons the residents, interns and students worked up the patients with careful histories and carried out special pediatric procedures under my supervision.

After one month the other pediatrician from California rotated with me and he came into the ship and I went to the University Hospital at Santa Clara. There I would make grand ward rounds every morning and act as the visiting consultant from North America and would help them discuss the care and treatment of their patients in the hospital ashore. Later in the day I would be the consultant in the outpatient department. In the outpatient department all new cases had to be seen before they could be admitted to the Ship. There were one pediatrician, 2 residents and 3 medical students who worked in the outpatient department and when an interesting case came up they would ask me to see it with them.

As you can see, there was a considerable opportunity to perform a lot more in teaching than was carried out in Peru when I was there in October, November and December 1962.

J. S. VEDDER, M.D.
Marshfield

Letters to the Editor are welcomed and will be published for informative and educational purposes as space permits. As with other material which is submitted for publication, all letters will be subject to the usual editing. Address all correspondence to: THE EDITOR, WISCONSIN MEDICAL JOURNAL, *Box 1109, Madison, Wisconsin 53701.*

Minutes of Council Meeting

MADISON, JULY 30, 1967

1. Call to Order and Roll Call

The meeting was called to order by Chairman Fox at the State Medical Society at 9:35 a.m. on Sunday, July 30, 1967.

Voting members present were Doctors Bayley, Nordby, Stoops, Carey, Sisk, McRoberts, Dettmann, Fox, Boren, Grand, Egan, Van Hecke, Chojnacki, Wright, Past President Drew, President Kief, and Speaker Behnke.

Others present: President-elect James, Vice Speaker Nereim, Doctors Hill and Picard, alternate delegates to the AMA, Doctor Simenstad, AMA trustee; Messrs. Crownhart, Koenig, Reynolds, Brower, Maroney and T. H. Murphy; R. B. Murphy, Tiffany, Gill, and White, consultants; W. J. Brown of AMA staff; Mrs. Anderson and Miss Pyre. Present for special orders: Doctor Geppert, chairman of the Commission on Scientific Medicine; Mr. Hyink of Seefurth–McGiveran and a representative of Prudential Insurance Company.

Mr. Crownhart paid tribute, on behalf of the staff, to Dr. Milton D. Davis who passed away on July 19, 1967.

2. Approval of Minutes

On motion of Doctors Grand–Chojnacki, carried, minutes of Council meetings on May 7 and May 10, 1967, were approved as distributed.

3. Oath of Office

The oath of office was administered by the chairman to H. G. Bayley, M.D., elected first district councilor in May to succeed President-elect James.

4. Implementation of Actions of House of Delegates

A. Recommendations of Doctor Kief as President-elect

Included in Doctor Kief's recommendations to the House of Delegates were proposals to create a new Commission to Study Pollution of State Resources; creation of a Commission on Safe Transportation, with removal of this activity from the Commission on State Departments; and creation of a Division on Alcoholism and Addiction in the Commission on State Departments.

Doctor Nordby questioned the necessity of a separate Commission on Pollution and suggested that it be estabilshed as a Division of the Commission on State Departments, at least until the scope of its activity be known.

However, since the House of Delegates had accepted all of the recommendations as presented, the Council took this as a directive and on motion of Doctors McRoberts–Grand, carried, directed that these actions be implemented.

In reference to the newly created Division on Alcoholism and Addiction, a number of nominations were made by Council members of physicians to serve as chairman or members of the division to be constituted at a meeting of the Commission on State Departments scheduled in August.

[DoctorKief subsecouently announced the appointment of D. A. Treffert, M.D., Winnebago, as chairman.]

With reference to Doctor Kief's recommendation on the Wisconsin delegation meeting with the

Council prior to and following each AMA meeting, which also was endorsed by the House of Delegates, he asked for an amendment to the extent that the Council take into consideration the practical impossibility for a Council meeting between the time material to be considered at an AMA meeting is received and the meeting itself.

The Council agreed on the basis that the AMA delegates and alternates are invited to all Council meetings and receive all mailings so that they are acquainted with its views, and further, that in event of some urgent matter the Executive Committee could be called into session on short notice.

B. Report of the Secretary to the House of Delegates

On motion of Doctors Nordby–Chojnacki, carried, the Council referred to the Planning Committee the report of the Secretary in May suggesting consideration to promotion of a national commission of professional groups to study such matters as abortion, human experimentation, automatic consent, liability of paramedical personnel, etc.

Doctor Chojnacki presented a statement of opinion by a group of physicians on the subject of abortion which he requested be referred to the committee with the above action.

5. Report of Planning Committee

By separate motion duly made, seconded and carried, the Council approved the following recommendations of the Planning Committee, with fiscal notes where determined:

A. Medical Student Orientation and Liaison

(1) That the State Medical Society become a sustaining member of the Student American Medical Association at $100 per year.

(2) That the Society provide a monthly report to students via the student newsletter printed at the Society, and that the two SAMA chapters be given space in alternating months in the Wisconsin Medical Journal for reporting to physicians, the approximate cost being $50 per page per month.

(3) That the Society offer staff representation at SAMA meetings to provide advice in the socio–economic aspects of their activities.

(4) That the Society makes its services available to set up programs and speakers for medical student meetings if desired.

(5) That the Society develop programs of a semi-informal nature in which the medical student and his wife or fiancee are presented with the practical aspects of medical care. Fiscal implications are to be developed along with the mechanisms required for implementation. This would include both SAMA chapters and the Woman's Auxiliary would be invited to sponsor events for the wives and fiancees. In addition, the staff is to explore the possible development of programs for classes other than the senior class.

(6) That the Society endorse the proposal to develop a method of increasing summer jobs and that such campaigns begin in January or February.

(7) That the Society increase financial aid as needed to increase the ability of student officers to participate in important meetings of the Society, SAMA, and AMA, and that the same be considered for the student auxiliaries within the limits of the budget.

B. Alliance for Progress

Nicaragua has been "adopted" by the State of Wisconsin as its "sister state" through the Alliance for Progress, with Henry Peters, M.D., serving on the Governor's committee.

The Planning Committee recommended that the Council express the willingness of the State Medical Society of Wisconsin to cooperate with the Nicaragua Medical Society in organizational matters.

The following resolution was adopted on motion of Doctors Chojnacki–Nordby, carried:

WHEREAS, The State of Wisconsin of the United States of America and Nicaragua are sister states by virtue of the Alliance for Progress; and

WHEREAS, The art and science of medicine know no political or geographic boundaries; therefore be it

Resolved, That the Council of the State Medical Society of Wisconsin expresses willingness to cooperate in any way possible with the Nicaragua Medical Society in its development of organization and the advancement of the science of medicine for the common good.

C. Group Air Tours

The committee reported review of the recent group air tour to Hawaii sponsored by the Society, and recommended that such tours be furthered in the future.

On motion of Doctor Drew, seconded and carried, this proposal was tabled.

6. Committee on Economic Medicine—Special Order

This committee had reported in May with reference to a proposal by the Prudential Insurance Company to provide a group pension plan for members of the State Medical Society, and recommended that it receive further consideration by the Council.

Mr. Hyink of Seefurth–McGiveran, insurance consultants, and a representative of Prudential discussed the formal proposal which had been sent to Council members. The plan includes provision for variable annuities as well as fixed dollar annuities.

In discussion, it was recommended that a comparative analysis with other retirement programs should be made, and that some determination should be made of the demand for a plan by physicians not already enrolled in one.

On motion of Doctors McRoberts–Wright, carried, the matter was returned to the Committee on Economic Medicine with these considerations.

7. Commission on Scientific Medicine — Special Order

T. V. Geppert, M.D., Chairman of the Commission on Scientific Medicine, appeared in its behalf to express the hope that the Council will give study to the matter of eliminating conflicts between administrative affairs of the annual meeting and the scientific sessions.

Doctors Egan–Grand moved that this be referred to the proper committee for study, and Doctor Fox stated that it would be considered by the Executive Committee.

8. Reports by Council-appointed Consultants

A. Legal and Legislative Counsel

Mr. Robert Murphy reported on the status of bills of major interest to the profession. He also commented on areas in which legal advice is ren-

dered on a continuing basis, and discussed some problem areas of the future commanding the Society's attention. Incorporated in his remarks were excerpts from communications by Messrs. Kluwin and Heider.

B. Actuary

Mr. Tiffany described his responsibility to the Council as requiring a continual surveillance of underwriting, rating and claim practices and results, and a monitoring of the competitive position of WPS so that it remains useful to the public, the medical profession, and ancillary providers of service. He said the plan was in good actuarial health.

C. Certified Public Accountants

Mr. Gill reviewed the functions of his firm in preparing audits of the eleven sets of books maintained by the Society, its divisions, and affiliated organizations; and providing consultation on accounting matters at the request of management or on their own motion when deemed advisable.

9. Report of the Secretary

Mr. Crownhart added comments from his own viewpoint on the value of services provided by the consultants, and reported that employment was now over 600 and rising; that additional space would be leased in a fourth building location; that he had plans for staff reclassifications, and that Mr. Thayer would be returning in socio–economic activities by year end. On inquiry, he said that the matter of salary would first go to the Finance Committee.

10. Report of Executive Committee

A. Dues for Members in Military Service

On motion of Doctors Chojnacki–Boren, carried, the Council approved the committee's recommendation, after reviewing current policy at the request of a councilor, that the policy be continued of refunding dues in the year of induction for that portion of the year remaining, but that dues be waived for the year of returning from service.

B. Membership on Councils and Committees of the AMA Board of Trustees

The Council accepted a slate of nominees, making several additions, to be submitted for consideration by the AMA Board of Trustees in constituting its councils and committees for the ensuing calendar year.

C. U. S. Chamber of Commerce

After receiving a report from Doctors Drew and Kief on their trip to Washington in May to visit members of Congress from Wisconsin and to attend the dinner associated with the annual meeting of the U. S. Chamber of Commerce, the Executive Committee recommended that plans be made to seek the attendance of four or five physicians in future years as representatives of the State Medical Society, and that the general body of physicians be encouraged to become members of Chambers of Commerce. This recommendation was approved by the Council.

D. Past Presidents Committee

The committee noted Council action in 1964 constituting the Past Presidents as a permanent committee of the Council, and recommended that it be reactivated and that appropriate matters be referred to it for deliberation and advice. This also was approved by the Council.

E. Resolution Commemorating Doctor Davis

The Council unanimously adopted a resolution introduced by the committee in commemoration of Milton D. Davis, M.D., to be printed in the Wisconsin Medical Journal (see August issue) and a copy sent to his family.

11. Councilor District Reports

District councilors present reported generally on activities in their respective areas. There were no problems commanding the specific attention of the Council.

12. Councilor Election

On motion of Doctors Nordby–Stoops, carried, M. F. Huth, M.D., Baraboo, was elected to the unexpired term on the Council of Doctor Davis.

13. Miscellaneous

Doctor Egan asked that a review be made of House of Delegates actions in May to assure that all are implemented in appropriate manner.

14. Adjournment

The meeting adjourned at 12:25 p.m.

C. H. Crownhart
Secretary

Approved:
James C. Fox, M.D.
Chairman
(Subject to formal approval by the Council.)

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the wisconsin medical journal

VOLUME 66/NUMBER 11 NOVEMBER 1967

Considerations In Management of Right Ventricular Failure in Cor Pulmonale

By DAVID E. DINES, M.D. and THOMAS W. PARKIN, M.D.

Rochester, Minnesota

■ IN ANY DISCUSSION of the management of congestive failure in cor pulmonale, factors important in the development of the problem, including hypercapnia, hypoxemia, and secondary polycythemia, must be considered. Hypoxemia and hypercapnia occur when alveoli are better perfused than ventilated. Patients with chronic obstructive pulmonary disease develop pulmonary hypertension from reduction in the pulmonary capillary bed brought about by hypoxemia and destructive alveolar changes. Hypoxemia and hypercapnia cause elevation of pulmonary artery pressure through vasoconstriction. With persistent hypoxemia, polycythemia develops, increasing the viscosity of the blood and further impairing the efficiency of the heart muscle. When the right ventricle can no longer compensate for the increased work load, the end-diastolic pressure in that ventricle rises, the venous pressure increases, and right heart failure ensues. Cases of right ventricular failure on the basis of cor pulmonale make up 40% of the cases of congestive heart failure.

Cor pulmonale implies right ventricular dilatation, hypertrophy, or failure secondary to pulmonary disease, and the presence of cor pulmonale implies severe, chronic respiratory disease. Hypoxemia, chronic carbon dioxide retention, polycythemia, and right ventricular failure may be present in varying degrees[1] in chronic cor pulmonale secondary to chronic obstructive pulmonary disease. Hypoxemia, polycythemia, and cor pulmonale are associated with increased frequency in patients who have chronic obstructive pulmonary disease with chronic bronchitis, the so-called blue bloaters. Congestive failure in the emphysematous group (the "pink-puffers") is usually a terminal event. The pulmonary hypertensive forms of cor pulmonale occur also because of multiple pulmonary emboli, pulmonary artery thrombosis, and primary pulmonary hypertension, and in chronic alveolar hypoventilation with hypoxemia (kyphoscoliosis, pickwickian syndrome, pulmonary fibrosis, or previous thoracoplasty).

Treatment with digitalis, diuretics, and sodium restriction is just as much indicated in right ventricular failure as in left ventricular failure. Contrary to the opinion expressed by earlier medical textbooks, digitalis is effective in patients with cor pulmonale and congestive failure, but it must be used cautiously to avoid intoxication. Patients with cor pulmonale and congestive failure often have been under treatment with thiazide diuretics and are hypokalemic, presenting with a metabolic alkalosis superimposed on a chronic respiratory acidosis due

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From the Mayo Clinic and Mayo Foundation, Section of Medicine.

Presented at the meeting of the Indianhead Chapter of the Wisconsin Academy of General Practice, Cable, Wis., Feb. 14–16, 1967.

Reprint requests to: Section of Publications, Mayo Clinic, Rochester, Minn. 55901.

Fig. 1—(Case 1). Roentgenogram showing cardiomegaly and pulmonary vascular congestion.

Fig. 2—(Case 2). Roentgenogram showing emphysema with large pulmonary arteries indicative of cor pulmonale.

to hypokalemia. Potassium should be administered orally as potassium chloride, and electrolyte values should be determined frequently.

Rest in bed may help bring about diuresis in some patients.

Oxygen therapy is indicated in the hypoxic patient. It should be part of the treatment in patients with cor pulmonale and congestive failure. The lowest flow rate that relieves dyspnea is indicated, beginning with 1 to 2 liters/min by nasal cannula. This rate can be increased safely by 1 liter/min each day to avoid accumulation of carbon dioxide.[2] Oxygen tents should be avoided, since they interfere with nursing care and do not provide effective oxygen concentrations. The use of oxygen must be carefully monitored by frequent determinations of pH and carbon dioxide tension during the day. Some patients with chronic obstructive pulmonary disease, cor pulmonale, and right heart failure require tracheal intubation or tracheostomy and artificial ventilation to control the rising carbon dioxide tension caused by somnolence and inability to handle secretions.

Patients are often polycythemic, and it is most important to lower the viscosity of the blood by daily phlebotomies (in increments of 250 ml) until the hematocrit value is about 50%. The hemoglobin concentration must be kept above 12.5 gm/100 ml to avoid making the patient iron deficient.

ILLUSTRATIVE CASES

Case 1.—A 58-year-old butcher was seen in the emphysema clinic because of chronic productive cough, light-headedness, increased somnolence, and lethargy. He had smoked two packs of cigarettes a day for 43 years.

He was plethoric, dyspneic, cyanotic, and overweight. He had grade 4 (basis of 1 to 4) expiratory slowing, coarse rhonchi throughout both lungs, and râles at the lung bases. The liver was palpated 7 cm below the right costal margin, and he had moderate pitting edema of extremities.

A thoracic roentgenogram (Fig 1) showed cardiomegaly and pulmonary vascular congestion. The electrocardiogram revealed right axis deviation of QRS and poor progression of the R wave across the precordium. Studies of pulmonary function (Table 1) disclosed the typical pattern of chronic obstructive pulmonary disease with chronic bronchitis. Carbon dioxide tension was 67 mm Hg (normal range: 40–45 mm Hg) and the pH was 7.34 (Astrup). The hemoglobin value was 16.5 gm and the hematocrit reading was 58%.

Treatment started through the emphysema clinic included instructions to lose weight, to quit smoking, and instructions in breathing exercises. He was instructed to inhale isoproterenol (Isuprel) nebulized with an air compressor four times a day, to take theophylline and glyceryl guaiacolate (Quibron) four times a day to help with the secretion problem, and to limit the sodium content in the diet to 2 gm. He was digitalized slowly with digoxin (Lanoxin). Phlebotomy performed on two successive days decreased the hematocrit reading to 50%.

He was instructed to return in three months for

TABLE 1—*Pulmonary function in case 1**

	Estimated normal	Patient	Patient after isoproterenol
Pulmonary volumes			
Vital capacity, L	4.7	1.85	1.89
Residual volume (RV), L	1.6	3.62	
Total capacity (TC), L	6.3	5.65	
RV/TC x 100 (%)	40	64	
Functional residual capacity, L	2.8	4.12	
Expiratory reserve, L	1.2	0.50	
Maximal breathing capacity, L/min	126	34	42
Maximal midexpiratory flow, L/sec	2.0	0.4	0.4
Expiratory slowing, grade	0	4	4
Nitrogen-washout index, % N_2	≦2.5	4.0	
Arterial oxygen saturation (oximeter), %			
Resting (air)	95–98	85	
Resting (oxygen)	100	100	
Before exercise (air)	95–98	89	
Exercise (air) for 1.8 min	No fall	76	
Exercise (oxygen) for 3.2 min	100	100	
Ventilation (at sitting rest, breathing oxygen)			
L/min		9.98	
Respirations/min		14.4	
Average tidal volume, ml		693	

*Data are characteristic of chronic obstructive pulmonary disease with chronic bronchitis in which the ratio of residual volume to total capacity is increased and total capacity is not increased. There is marked obstruction, with marked decrease of maximal breathing capacity and of maximal midexpiratory flow, minimal increase in nitrogen washout, and profound arterial oxygen unsaturation.

TABLE 2—*Pulmonary function in case 2**

	Estimated normal	Patient	Patient after isoproterenol
Pulmonary volumes			
Vital capacity, L	4.7	1.89	2.57
Residual volume (RV), L	1.6	6.31	
Total capacity (TC), L	6.3	8.25	
RV/TC x 100 (%)	45	76	
Functional residual capacity, L	2.8	6.98	
Expiratory reserve, L	1.2	0.67	
Maximal breathing capacity, L/min	92	23	33
Maximal midexpiratory flow, L/sec	2.0	0.3	0.4
Expiratory slowing, grade	0	4	4
Nitrogen-washout index, % N_2	≦2.5	7.4	
Arterial oxygen saturation (oximeter), %			
Resting (air)	95–98	99	
Resting (oxygen)	100	100	
Before exercise (air)	95–98	98	
Exercise (air) for 5.0 min	No fall	96	
Exercise (oxygen)	100		
Ventilation (at sitting rest, breathing oxygen)			
L/min		10.54	
Respirations/min		10.6	
Average tidal volume, ml		538	

*Pattern is typical of chronic obstructive pulmonary disease with emphysema. There is marked increase in residual volume and in the ratio of residual volume to total capacity. Nitrogen washout is high, and maximal breathing capacity and maximal midexpiratory flow are markedly lowered.

reexamination and for a decision regarding a graduated oxygen-supported exercise program.

Case 2.—A 73-year-old retired fireman seen in the emphysema clinic gave a history of progressive dyspnea of 10 years' duration. He had been a heavy smoker for 35 years, but had stopped smoking 8 years previously and had not been bothered with cough since then.

He became dyspneic from dressing, and had grade 4 expiratory slowing. Expansion of the thorax was diminished, and the hemidiaphragms moved less than 1 cm. Atrial fibrillation was present, and the ventricular rate was 120/min.

A thoracic roentgenogram (Fig 2) showed emphysema, with large pulmonary arteries indicative of cor pulmonale. Studies of pulmonary function showed the typical features of chronic obstructive pulmonary disease with emphysema (Table 2). The hemoglobin concentration and hematocrit reading were normal. Blood pH was 7.4 and carbon dioxide tension was 65 mm Hg, indicative of compensated respiratory acidosis.

The patient was digitalized with digoxin (Lanoxin), given a diet low in sodium content (2 gm), and instructed in breathing exercises. He was also instructed to inhale isoproterenol nebulized with a DeVilbiss size 40 nebulizer and a 501 air compressor four times a day, and to take oxtriphylline (Choledyl) four times a day, and potassium iodide twice a day.

COMMENT

Of the two patients with chronic obstructive pulmonary disease, one had chronic obstructive pulmonary disease and chronic bronchitis, cor pulmonale, congestive failure, and secondary polycythemia, while the other had chronic obstructive pulmonary disease and emphysema, cor pulmonale, and atrial fibrillation. In both, therapeutic efforts have been directed toward the underlying pulmonary disease as well as toward the congestive failure and atrial fibrillation. One patient was hypoxic, and both were hypercapnic. Improved alveolar ventilation must be achieved in cor pulmonale with right heart failure by vigorous treatment employing nebulization by intermittent positive-pressure breathing or air compressor, bronchodilators, expectorants, and antibiotics when infection is present.

In the patient with cor pulmonale, an increase in heart rate reflects pulmonary as well as cardiac insufficiency. The use of digitalis to control increased heart rate can result in overdosage. Digitalis toxicity in patients with cor pulmonale is not uncommon, and severe digitalis-induced atrial arrhythmias, especially atrial tachycardia with block, may occur.

Isoproterenol acts like epinephrine on the heart; consequently, the dosage must be decreased when the patient is taking digitalis, but the two drugs can be used concomitantly.

Most patients who have recovered from right heart failure have some pulmonary hypertension on exercise. The pressure elevation is due to the anatomic reduction in the pulmonary vascular bed. Even these patients with severe respiratory insufficiency and pulmonary hypertension can be rehabilitated

with oxygen-supported exercise training.[3] Oxygen-supported exercise improves cardiopulmonary function and improves motivation, thereby making greater physical independence possible.

A vigorous approach[4] to the underlying pulmonary disease is indicated, since prognosis depends primarily on the course of the pulmonary disorder rather than on the circulatory complications.

SUMMARY

In most cases, chronic cor pulmonale is due to chronic obstructive pulmonary disease. In the management of right ventricular failure in chronic cor pulmonale, consideration must be given to hypoxemia, chronic carbon dioxide retention, polycythemia, and the possibility of electrolyte imbalance. Patients with chronic pulmonary insufficiency and cor pulmonale are prone to develop metabolic alkalosis superimposed on respiratory acidosis due to hypokalemia. Digitalis can be used safely as a rule, but potassium supplements must be administered concomitantly. A vigorous approach to the underlying pulmonary disease is indicated, since prognosis depends primarily on the course of the pulmonary disorder rather than on the circulatory complications.

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Counseling in Marriage Problems for Physicians

"When you include the psychosomatic reactions resulting from hidden marriage tensions, it seems very probable that more marriage problems are brought to medical doctors—be they general practitioners or specialists—than to any other kind of professional helper.

"Those who seek the physician's counsel on marriage problems have a great variety of complaints. Some openly ask advice about specific problems ranging from budgeting to mothers-in-law and from sexual techniques to how to cure an alcoholic husband. Sometimes these questions are related to the professional specialty of the physician, sometimes they are not.

"There is another large group of people who do not ask directly for marriage help at all. However, the physician soon sees a tantalizingly obvious association between their functional complaints and the marital problems which they have either openly or guardedly revealed.

"All of these people have one thing in common—they need some marriage counseling. But many of the physicians to whom they have come feel unprepared to deal with the problems presented and are reluctant or unable to refer these patients to others. Of 514 North Carolina physicians included in (a) recent study . . . . 283 reported that there was little in their medical school training which had helped them to deal with marital maladjustment, and 342 reported that no helpful experience had been gained during internship or residency. Moreover, 78 per cent of those interviewed indicated that they rarely or never made referrals for marriage counseling, and 7 per cent of those interviewed said they refused to discuss marital problems even in response to the patient's request.

"Clearly, there is a need for a greater understanding by the physician of what he can do with marriage problems, both in treatment and in referral."

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Social and Medical Responsibility in Suicide Prevention

By CARL I. WOLD, Ph.D.
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■ WITHIN RECENT YEARS there has been an increasing recognition of suicide as a major public health problem. Moreover, it has become clear that the physician has a vital role in suicide prevention. Nationwide, suicide ranks among the ten leading causes of death, accounting for at least 25,000 deaths annually. In Los Angeles County last year there were 1,400 officially certified suicides, more than traffic fatalities. This means a rate of death of about 18 per 100,000, which is comparable to the state of Wisconsin. Of course, these are minimal figures since suicide is under-reported. More than this, there is incomplete agreement about certifying suicide among the various counties in the United States.

But what of the physician? What is his role in suicide prevention? Three out of every four people who kill themselves have been seen by a physician within six months prior to their deaths. What are the prodromal clues? How are suicidal people to be evaluated and what can be done? This communication will discuss these questions and raise a few.

With the increased awareness of suicidal problems has come a developing professional interest in understanding suicide and preventing it. There have been a number of articles published by members of the staff from the Suicide Prevention Center in Los Angeles, especially the co-directors, Drs. Robert E. Litman and Norman L. Farberow. Doctor Litman is Chief Psychiatrist, in addition, and has written articles regarding the physician's role in suicide prevention.[1, 2, 11] Another focus of concern and activity has come from the Woman's Auxiliary to the American Medical Association representing some 84,000 members.[3] As a community service project, the Auxiliary set itself a goal of stimulating cooperation between the police and physicians in suicide prevention activities and training. They report a successful program in Greensboro, N.C.

SUICIDE POTENTIALS

Who are the people who do kill themselves? Their backgrounds, life situation, personality, and symptoms are varied; and they may arrive at the act of suicide from many different paths. Some are young people, adolescents struggling to be free and independent of the family. More often than not, the adolescent girls have led chaotic lives and show a good deal of emotional disturbance. In their history they have been identified as troubled by counselors, the school, or the law, and may have a history of psychiatric treatment. The more frequent adolescent suicide is the young man doing adequately in school and superficially problem-free. He tends to keep his troubles to himself, and his family and friends are unaware of his serious thoughts. In spite of this guardedness, there may be indirect warnings given by these suicidal young men.

Parents, the school, and physicians should pay attention to changes in usual patterns of behavior. Depression might show itself through the giving away of cherished, personal items such as skis or automobile accessories, or perhaps through physical complaints which lead to the doctor's office. Often strong fears of failure are present, making school achievement a struggle and relationships with girls painful.

With young adults, suicide arises in the context of establishing occupational and marital success. For some young women from chaotic family backgrounds, life is an unstable pattern of repeated failures with men.[4] Such a woman may become suicidal in response to separation from or loss of a man.

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Some middle-aged men who become suicidal may also be guarded and not overtly disturbed. Often such men have led fairly stable and ostensibly successful lives with substantial achievements in the area of work. In what has been described as a quiet crisis,[5] depressive feelings may be indirectly expressed as with the adolescent boys. In addition to behavioral clues, there may be subtle, indirect clues to those people closest to the man. Such expressions as "You may not be seeing me around much anymore," and comments about life losing its meaning should alert those closest to the depressed man.

Behavioral clues, like a sudden need to put his financial affairs in order, are particularly important. Increases in irritability and dissatisfaction may be expressions of depression. I received a call from a wife concerned about her 45-year-old veterinarian husband. He was a successful and stable professional man in the community, but his actions over the last couple of months had worried his wife. What brought her to call was his visit to an attorney friend arranging a new will. She reported that he had talked informally with physician friends about some rather vague physical complaints; yet a thorough check-up revealed no reason for medical concern. When I talked with him, he was irritable and tended to minimize the difficulties. In talking, it became clear that his irritability was severe and it had begun to antagonize some of his clients. It occurred to me that he might be suicidal, so I asked him. At first he was hesitant to talk about it but then revealed a fairly detailed suicidal plan which he had been thinking about and had told to no one. An immediate psychiatric referral was arranged to which this man responded well, and as an outpatient he dealt with his depression enough to return to his former high level of functioning.

Contrary to prevailing beliefs, old people account for only about 10% of suicides. A number of these old people are alone, progressively alienated from family and friends through the years. Chronic, debilitating illnesses may have been present and resulted in a progressive loss of vitality and energy. Psychological concomitants to infirmity are seriously damaged pride and loss of self-esteem. With some older people, struggles to maintain youthfulness co-mingle with suicidal preoccupations.

DEPRESSION AND HOPELESSNESS

From the foregoing, it is clear that suicide is a complex and multi-dimensional problem and is manifest in different people in a variety of ways. A generalization that can be made is that suicidal people have lost hope. Strong feelings of hopelessness lead to a give-up attitude, often accompanied by physical complaints. Moreover, feelings of hopelessness are infectious. The physician who treats the depressed patient experiences those same feelings of hopelessness, especially with chronic, downhill course of illness. Often the result is feelings of irritation toward the patient.

To illustrate this, I want to report an event which occurred during the training of medical students in suicide prevention activities. As I talked about these problems, a fourth year medical student who had been seeing an elderly woman suffering from emphysema told me that he understood quite well how his patient made him feel depressed. Furthermore, he told me that he would reassure this woman since he felt this to be his medical responsibility, but that it could not come from his heart. Inside, indeed, he did feel hopeless for her and, with difficulty, admitted to himself that suicide might be an appropriate solution. I was about to answer him when another student interjected. He said that he too had been seeing a woman with emphysema. He happened to discuss the case with a fellow student who recommended the possibility that she become involved in community service activities. The student suggested this to the patient, and before long she began active work in community affairs, limited, of course, by her physical disability. Using the telephone, however, she was able to get a lot of work done. The changes in her feelings were remarkable. She began to feel worthwhile and confided to her doctor that this now was one of the better periods of her life.

This incident illustrates a number of important points. First, feelings of depression and hopelessness are infectious. Secondly, when depressed, the physician is hindered from developing creative plans for the patient. Third, informal consultation with a colleague provides an invaluable tool for developing creative solutions to apparently insoluble problems.[6]

Consultations with colleagues serve another purpose. Some of the irritation which we feel toward depressed and suicidal

patients reflects our feelings of hopelessness. Patients may die, in fact, may kill themselves in spite of our efforts. A consultation helps reestablish perspective when treating serious cases. Another function of the consultation is to share responsibility for an important decision to be made.

PREVENTIVE PLANS

After the physician determines that a patient is suicidal, how should he proceed? An assessment of suicide potentiality is required.[2] Our experience in Los Angeles has been reassuring in discussing suicidal feelings with patients. We have found no evidence that asking people about suicidal feelings suggests thoughts or promotes action which otherwise would not have occurred.

Details about the suicide plan are important for assessing suicide potentiality. Certain methods, such as a gun, are more lethal and provide less chance for rescue. Barbiturates, although the leading method of suicide in Los Angeles County, may provide time for intervention. The more specific and detailed the plan, the higher the suicide risk. Moreover, a history of prior suicide attempts increases the risk as well. Often a person's suicidal history reveals that in a series of suicide attempts, they become progressively more lethal. About 80% of people who kill themselves have a history of prior suicidal episodes.

People who are high suicide risks may present intense and varied symptoms. Depression shows itself in appetite and sleep disturbances, feelings of hopelessness and helplessness, and withdrawal from meaningful contacts with other people. Anxiety, even panic, may be present. A frequent, complicating symptom is confusion. During a suicidal crisis, the patient may be observed to be quite constricted and immobilized. Talking with the patient, the physician may be aware of confused and disorganized thinking.

The more good resources there are in a suicidal person's life, the lower the suicide risk. People with family, friends, an employer, a clergyman, or a physician who is concerned and interested, have invaluable resources during time of crisis. People who are alienated from others, down-and-out or without employment, are more difficult to help.

The external stresses on the suicidal person are important to consider when evaluating suicide potentiality. A most frequent and meaningful stress is a personal loss. If the suicidal person has lost an important relationship with a spouse or friend, specifically, a divorce or death or the breakup of a romance, the suicide risk is increased. Other stresses to consider are legal involvement, especially when embarrassing or humiliating activities threaten to become public. Major financial setbacks, in fact, failure at any important activity can be an important stress to consider.

Finally, learning about the person's character can help the physician assess the suicide potentiality. People with stable ways of living and personality may go into an acute suicidal crisis, but the prognosis is good if emergency help is forthcoming. Unstable people with a history of chronic failure may be high risks and more difficult to help. Although only about 10% of those who kill themselves could be diagnosed as schizophrenic, the presence of psychotic symptoms increases the risk of a suicide.

Special mention should be made about the problem of barbiturates. When you examine the methods people use to kill themselves in Los Angeles County, there has been a steady, significant increase in barbiturate deaths. Retrospective studies of suicides often reveal abusive use of prescribed barbiturates. These people rely heavily on medication and misuse it, frequently taking pills and alcohol concurrently. Over-reliance on hypnotics by a patient should alert the physician and may call for a consultation.

HOSPITAL OBLIGATION

Litman, Farberow and others have written about the hospital's obligation toward suicide-prone patients.[7] Litman reports a study of 14 patients, over a two-year period in Los Angeles, who committed suicide on general medical surgical wards.[7] Thirteen of the 14 who died were men. Eleven of the 14 suicides resulted from a fall. These people were killed falling from a high window or an upper floor stairwell. Most were older people, either depressed or clearly confused, and their suicides were impulsive acts. The patients had been hospitalized for a variety of physical illnesses. An example given was a 50-year-old man who became confused four days following gallbladder surgery. He pulled out his catheter and wandered around the ward, explaining that he was looking

for a basketball. He was given sedatives and tranquilizers. Nevertheless, he demanded a change in his room and while this was arranged, the attendant left him momentarily to get his clothes, and the patient jumped out of a window. From these findings, Litman suggests that special precautions are necessary for patients who may become temporarily depressed or confused with the chance of falling from a dangerous height. Safety devices such as screens to protect windows, doors and stairwells, should be considered.

During that same two-year period, Litman reported 12 suicides among patients at psychiatric hospitals or on psychiatric wards.[7] These deaths seem to present different problems than those occurring in the general medical and surgical hospitals. The more frequent method of suicide on the psychiatric wards was hanging. Their average age is younger, around 44 years. Many of these patients had a history of prior suicidal episodes. More often these patients are known to be suicidal, and management calls for special precautions prescribed by the physician. Margolis and coworkers[8] recommended that each suicidal patient on a psychiatric ward should be the focus of an emergency staff conference where the therapeutic roles of physicians, nurses, and the entire staff can be discussed. The results of this should be reported in the medical charts. More detailed directions should be given than the routine order of "suicide precautions."

SUICIDAL CLUES

Farberow, Shneidman and coworkers[9, 10] have studied the charts of over 300 patients who committed suicide at Veterans Administration hospitals over a period of nine years. These authors identify the following factors as important in identifying suicide-prone patients: (1) emotional stress; (2) severe depression and anxiety; (3) dejection, agitation or overdependency; (4) low tolerance for pain or discomfort; (5) excessive demanding and complaining behavior with strong need for attention and reassurance; (6) controlling and directing activity [for example, insistent requests for or refusals of treatment and medication]; (7) relative alertness in orientation; (8) exhaustion of resources, physical and emotional, including lack of support and attention from the family and hospital; (9) prior or present suicide attempts. They stress the importance of special attention to those patients described as dependent and dissatisfied. This is the patient who makes incessant demands on the staff by requests to see a doctor, the nurse, the chaplain, or excessive demands for service, including physical examinations, dental work, sedation, or various kinds of therapy. Their attitude of demanding from the staff and being dissatisfied with whatever is done is irritating and disturbing to other patients as well as the staff. These demands may indicate deeper trouble and should be regarded as serious from the standpoint of suicide potentiality.

More frequent than suicide among patients on hospital wards are those suicides which occur soon after discharge from the hospital. Most authors report this and feel that the period three months subsequent to discharge is important. The transition from hospital patient to resumption of life outside of the hospital may be a serious stress for suicide-prone patients. How much responsibility can the hospital and its staff assume for discharged patients? It does not seem unreasonable to consider after-care and follow-up when the possibility of suicide exists. Prior to discharge some after-care planning should be discussed, and Shneidman reports that nursing notes are particularly useful in formulating such plans. Of the hospital patients who will eventually commit suicide, about half of them do so within three months after discharge.

In recent years the role of the physician in suicide prevention has been recognized not only in office practice and in hospitals but also in community emergency services. In addition to traditional emergency medical units, a number of crisis service centers have developed throughout the United States. These vary in organization and staffing, yet share a common focus on personal crises using an emergency telephone service for people in trouble. People in crisis, including those who are suicidal, call in and are immediately evaluated and helped by telephone. Some of these crisis centers have been established as part of hospitals, and some function independently. In recognition of these centers, and the need for nationwide suicide prevention activities, the National Institute of Mental Health has recently set up a Bureau to encourage crisis services and stimulate research.

SUMMARY

In summary, physicians come in contact with suicidal patients during their medical practice in offices, hospitals, and emergency service centers. Pre-suicidal patients do communicate their feelings, sometimes indirectly, and these prodromal clues should alert the physician and stimulate further exploration. Suicide occurs in people with a variety of personal and cultural backgrounds and with different presenting symptoms. The emergency service to the suicidal patient requires combatting feelings of hopelessness and counteracting immobilization. The physician should stimulate creative action by discussing suicide frankly with the patient, utilizing family, friends, and community agencies when appropriate.

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RHINOMETRIC EVALUATION OF A NASAL DECONGESTANT SPRAY

JAMES K. MARTINS, MD, Eau Claire, Wis.: *Clinical Medicine* 73:70–72 (Aug) 1966.

A rhinometric study of the nasal decongestant effects of oxymetazoline was done on 51 male college students with stuffy noses resulting from colds.

Improvement of from 20% to 79% over initial values occurred in 37 (73%) of the patients treated with oxymetazoline. All but 5 of these showed an improvement of airflow of 40% or more. Onset of action occurred within one half hour in 29 patients and within one hour in 8 others. Initial improvement was maintained for five or more hours in 34 of the 37 patients who improved. All 37 reported improvement in breathing, but the subjective response proved only a crude measure of the increased air flow.

The rhinometric data obtained were concordant with previously reported clinical data on the onset and duration of action of oxymetazoline.

The clinical impression of oxymetazoline as an effective long lasting nasal decongestant is confirmed by rhinometric air flow study.

A technique of rhinometry here described proved to be adequate for quantification of nasal airflow.

BOOKLET FOR UNDERSTANDING CHILDREN IN HOSPITALS

"Red Is the Color of Hurting," a booklet on planning for more humane and understanding services for children in medical hospitals, has just been published by the U. S. Public Health Service.

The illustrated booklet is based on proceedings of a workshop held at the Annual Meeting of the American Orthopsychiatric Association in New York in 1965 and supported by the National Institute of Mental Health.

The motivating factor in the conference was the recognition that most hospitals, while caring for the medical needs of ill children, often fail to consider the emotional crisis engendered in the life of the child and his parents when hospitalization is necessary. Separation from parents, anxiety about the setting, loneliness, lack of recreation, and many other personal factors can have serious damaging effects on the child's mental health, the participants felt.

There was general agreement that "what happens, and what does not happen, to the sick child to a great extent determines the nature of his behavior not only within the hospital but for a long time after he has returned home."

The participants included outstanding men and women in pediatrics, nursing, psychiatry, psychology, cultural anthropology, and architecture.

Among their suggestions were to provide adequate facilities for mothers or mother substitutes to be near the child, with living-in arrangements particularly for mothers of children under five or those fatally ill; assistance to parents with problems relating to the child's illness; mental health orientation in the training of personnel; flexibility in architecture; and innovations that consider the rapid changes taking place in medicine.

Single copies of the booklet, Public Health Service Publication No. 1583, are available from the Public Inquiries Branch, U. S. Public Health Service, Washington, D. C. 20402.

MAMMOGRAPHY

By J. GERSHON–COHEN, M.D., D.Sc. (Med.)
Philadelphia, Pennsylvania

■ THE VALUE OF MAMMOGRAPHY has been the subject of discussion, even controversy, since 1913, when it was first broached by Salomon.[1] Now that it has been investigated and its merits affirmed by radiologists the world over, its place in the diagnostic armamentarium seems firm.[2, 3] It is presently conceded by most conscientious clinicians that, in evaluating any breast problem, to omit roentgenography is to do less than a "complete" examination.

Egan[4] deserves special credit for the recognition accorded the discipline as a means of achieving more accurate diagnosis of breast cancer. A growing body of reports by other investigators attests that mammography can demonstrate minute cancers before they are palpable, before they have metastasized, and—most important of all—before the accepted classic signs of malignant tumor appear. At operation, a sizable number of these cancers are found to be Stage 1, still localized and completely extirpatable. It is calculated from reliable statistics that some 70% to 80% of women whose lesions are in this category will achieve a 5-year survival, compared with 45% to 50% for women who discover their lesions by self-examination, which occurs in 95% of cases. Despite their diligence, the tumor first palpated by women usually averages 3.5 cm in diameter and in 65% of cases has already spread to axillary lymph nodes, drastically reducing their chances for cure (Fig 1).[5]

The techniques of mammographic examination are now so well known that they will not be restated here.[4, 6] The importance of the curious punctate calcifications that are often pathognomonic of tiny cancers, particularly those of the duct-cell or scirrhous types, and which were first described by Leborgne,[7] has been repeatedly confirmed In many instances, the presence of these microcalcifications and their distinctive characteristics have resolved an otherwise equivocal diagnosis.[8]

MAMMOGRAPHIC SCREENING STUDIES

Because several hurdles of some magnitude have yet to be overcome, screening surveys of asymptomatic women have not been done frequently. However, those that have been accomplished have produced exciting results. Witten and Thurber,[9] who examined more than 5,000 women admitted to hospital for reasons other than for breast complaints, found 8 unsuspected cancers, an incidence of 1.6 per 1,000. The radical mastectomy specimen in each instance was free of axillary lymph node metastasis.

Wolfe,[10] in his survey of 3,891 women, reported finding 16 cancers (4.11 per 1,000), one as small as 5 mm in diameter. In 14 of the 16 cancers removed surgically, there was no evidence whatever of regional spread. Stevens and Weigen,[11] who screened 1,223 asymptomatic women over 40 years of age, found 8 cancers, all of them unsuspected clinically until retrospective reexamination. None were associated with axillary metastasis at operation.

The drawbacks to such screening surveys are several. There is a shortage of qualified radiologists; the screening venture is costly in time and money for individual roentgenologists to assume; and there is a dearth of experienced technicians. The study being conducted by Shapiro et al.[12] in New York under the auspices of the USPHS is noteworthy for its scope. The project's goal is the eventual screening of some 15,000 women, with an additional 15,000 women serving as controls. Their preliminary report, which has already been published, is encouraging. To date, they have found 2.3 cancers per 1,000 women screened. The final report is eagerly awaited.

RESULT OF AUTHOR'S 10-YEAR SURVEY

A 10-year screening survey was recently completed by the author and his colleagues

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Presented at the 126th Annual Meeting of the State Medical Society of Wisconsin in Milwaukee, May 9–11, 1967.

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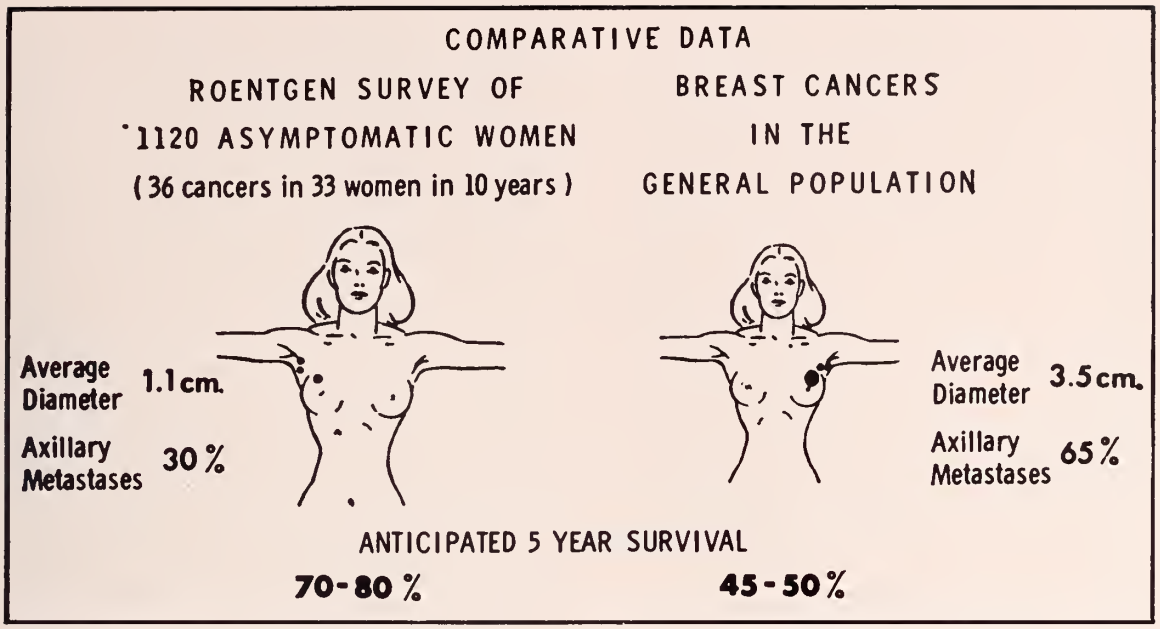

Fig. 1—Statistical comparison of cancers found by survey with those found by physical examination.

at the Albert Einstein Medical Center of Philadelphia. Some 1,120 women were enrolled as volunteers in the project, all of them over 35 years of age and free of breast complaints by design when the program began. With rare fidelity, they reported at 6-month intervals for mammographic examinations.

At the end of the 10-year study (January 1956–December 1965), 36 cancers had been found in 33 women, including bilateral cancers in 3 cases. The average size of the lesions was 1.1 cm; the diameters ranged from 0.4 to 3.5 cm. Axillary metastasis was present in 11 cases, or only 30%. Survival statistics indicate that about 80% of these women should attain 5-year survival.

Most of the women in the group were white (99%) and more than 65% were Jewish. Table 1 lists their age distribution by decades. The average age of the group was 52.4 years, ranging from 37 to 77 years. The ages of the 3 patients with bilateral cancers were 43, 47, and 59 years. None of the bilateral cancers were discovered simultaneously; 1, 7, and 2 years, respectively, separated their subsequent detection (Table 1).

One of the most important revelations of the survey was the value of periodic versus single examinations. During the first three years of the study, 18 cancers were found. In the next three years, 10 more were detected. In the final 4-year period, 8 cancers were found in this same group of women. Had the screening program been limited to one year, only 4 cancers would have been uncovered, whereas in the second year 9 more were found (Table 2).

Of the 36 cancers discovered roentgenologically, 20 were not suspected either by the clinician or the consultant surgeon because physical signs were absent. In the remaining 16 cases, although some physical symptoms suggested the need for biopsy, in only 12 was there a palpable mass that might have been considered "dominant." It is especially significant that in the three patients with bilateral cancers, the x-ray discovery of the second lesion *was not sup-*

TABLE 1—*Age distribution by decades of breast cancers in 1,120 healthy women during a 10-year period of mammographic screening*

Decades	No. of Volunteers	No. of Cancers	Patients with Bilateral Cancers*	Comments
35–39	67	1		Average age of patients with cancer: 52.4 yr.; range: 37–77 yr.
40–49	168	15	2	
50–59	448	13	1	
60–69	280	4		
70–79	157	3		
TOTALS	1,120	36	3	

*Ages of patients with bilateral cancers and interval between discovery: age 47, 1 yr.; age 43, 7 yr.; age 59, 2 yr.

TABLE 2—*Yearly sequence of cancer discoveries in survey*

Year	Number Discovered
1956	4
1957	9
1958	5
1959	3
1960	4
1961	3
1962	1
1963	2
1964	3
1965	2
TOTAL	36

ported in a single instance by suspicious clinical findings.

The types of cancer as diagnosed by the pathologist were as follows: 21 infiltrating duct-cell, 8 scirrhous, 3 medullary, 3 lobular, 1 sarcoma.

The microcalcifications associated with breast cancer and considered so important to roentgenographic diagnosis occurred in 12 of the 36 cancers in this series. In 6 of these, the diagnosis of cancer was made solely on the basis of microcalcific deposits not associated with a mass, a circumstance that led the surgeon to procrastinate from 4 to 24 months because of skepticism. When the radiologist's opinion was accepted and the suspicious area excised, the pathologist then joined the team effort by allowing the radiologist to localize for him the precise location of the malignancy and its removal for pathologic confirmation, which occurred in many cases on an *in situ* basis.

DISCUSSION

For the 10-year period, the discovery of breast cancer in 33 of 1,120 asymptomatic women in this survey is equivalent to an incidence of about 295 per 100,000, or almost twice the statistically anticipated rate in the age group of 55 to 59 years. The finding of bilateral cancers in 3 of the 33 women, an incidence of 9%, is a percentage to be expected.

Based on our experience with mammography during the past 30 years, it is our firm belief that this discipline reveals cancer with remarkable accuracy, approximately 90% to 95% when the radiologist interpreting the films is properly trained. On the other hand, we have found that in 6% of cases the consultant clinician or surgeon will make an unequivocal diagnosis of cancer when the roentgenologist fails to recognize the lesion, either because of technical errors, inexperience, or inability to discern the tumor in dense, glandular breasts. The opinion of nonradiologic colleagues, therefore, should never be ignored, but enthusiastically welcomed, for obviously the maximal benefits of mammography are to be derived by a concerted effort which utilizes the skills of surgeon, radiologist, and pathologist.

Gilbertsen,[14] feels that Stage 1 lesions can be detected by physical examination alone in 70% of cases if the examiner is highly trained. Since the ideal goal of having an expert radiologist examine every breast, whether asymptomatic or the seat of complaints, cannot be attained so long as sufficient radiologists are not available, perhaps the wisest program to pursue is to have the patient examined physically twice a year, with mammography done yearly as an auxiliary measure.

The sobering fact that breast cancer mortality data have failed to yield for 30 years to advances in surgery, radiotherapy, and chemotherapy, indicates the need for methods of earlier diagnosis than mere physical examination can provide. Mammography, although a gross diagnostic procedure and still an imperfect one, may be the key to improving the picture. Both in symptomatic and asymptomatic breasts it has proved its unique merits. The value of the procedure in screening surveys, while not yet conclusive because of the small numbers of women so far involved, appears to hold considerable promise. Hopefully, this promise will be validated as greater numbers of women are screened in greater numbers of surveys over increasing periods of time. The results of the 10-year project reported here are highly encouraging.

SUMMARY AND CONCLUSIONS

Periodic mammographic studies of some 1,120 women over 35 were performed for 10 years at 6-month intervals. Cancer was found unilaterally in the breasts of 33 of these women and bilaterally in the breasts of 3 of them during subsequent examinations one, two, and seven years later. The average diameter of the lesions was 1.1 cm., and axillary metastases were absent in 70% of cases.

According to published statistics, some 80% of women with lesions in this category (Stage 1) should survive 5 years, compared with a prevailing rate of 45% to 50% for

women who discover their own lesions by self-examination. It is hoped that these conclusions can be substantiated by statistically significant numbers of women, so that mammography as a breast cancer screening discipline can be more seriously entertained, possibly as a public health venture comparable to the Papanicolaou smear test for cervical cancer, which has been so successful.

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DISAPPEARING GALLSTONES

FRED SCHALDACH, M.D. and S. D. WILSON, M.D., from the Division of Surgery, Marquette University School of Medicine, the Allen-Bradley Medical Science Laboratory, and the Surgical Services of the Milwaukee County Hospital, Milwaukee: *American Journal of Surgery* 113:680–681 (May) 1967.

The case history of a thirteen year old mother who had typical attacks of acute cholecystitis is presented. Oral cholecystography demonstrated thirteen stones in her gallbladder on multiple views. She underwent cholecystectomy five days later; during this interval she had been entirely asymptomatic.

At surgery, only two stones remained in the gallbladder and none were found in the bile ducts. This asymptomatic passage of gallstones may account for some of the cases of "acalculous cholecystitis" which have been reported recently.

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ELEVENTH ANNUAL FELLOWSHIP PROGRAM ANNOUNCED BY WYETH LABORATORIES

Applications for two-year Wyeth Pediatric Fellowships are available now for residencies commencing July 1, 1968, it was announced by the chairman of the Selection Committee, Philip S. Barba, M.D., past president of the American Academy of Pediatrics, 120 Erdenheim Road, Philadelphia, Pennsylvania 19118. All applications for this, the eleventh group of Fellowships, must be in the hands of the Committee by Dec. 1, 1967.

Sponsored by the Wyeth Fund for Postgraduate Medical Education, each of these fellowships provides $4,800 over two years toward the advanced training required for board certification in pediatrics. Wyeth's monthly payments, made directly to recipients, are in addition to the usual stipends paid to residents by the institutions in which they train.

Eligible to apply are interns, physicians who have recently completed an internship, research Fellows, or physicians completing their tour of duty with the Armed Services or the U. S. Public Health Service. Applicants must be citizens of the United States or Canada. Those who have already started Pediatric Residency training are not eligible.

A voluntary committee of distinguished pediatricians considers the following factors: evidence of good character, academic achievement, performance of duties, and need for financial assistance. Wyeth plays no part in the selection of recipients.

Wyeth Laboratories inaugurated this Fellowship program in 1958 to encourage interns and other young physicians who want to specialize in pediatrics, who have proven abilities, but who would find it difficult to finance the required postgraduate training.

* * *

THE AMERICAN CANCER SOCIETY has launched a new series of films, as part of its expanding program of professional education. Oral cancer, nursing cancer patients, diagnosing and managing colon-rectum cancer, are a few of the subjects presented in these new color films. For more information and arrangements for showings, call your local ACS office.

Therapeutic Dilemmas

No. 3 of a Series

Editor:

HARRY BECKMAN, M.D.

Houghton Fellow in Clinical Research and Consulting Physician, Columbia Hospital

COLUMBIA HOSPITAL, MILWAUKEE

These are recorded reports, which have been edited, of conferences held on Tuesday mornings, 8–9, involving participation by members of the staff of the hospital, interns, residents, and guests. They will be published in a selective manner periodically in the WISCONSIN MEDICAL JOURNAL.

VENTRICULAR TACHYCARDIA

Moderator: DAVID C. MOUNTAIN, M.D.

Participants: A. JAMES BUTTLES, M.D.
GHOLI DARIEN, M.D.
FRANCIS F. ROSENBAUM, M.D.

Dr. David C. Mountain: The case this morning is one of ventricular tachycardia, which provides very interesting problems in both diagnosis and therapy. Doctor Buttles will present the protocol.

Dr. A. James Buttles (Resident in Medicine): The patient, a 75-year-old retired salesman, was admitted to the hospital on Jan. 31, 1967, with the complaint of severe substernal pain radiating to the left shoulder, and nausea. Examination revealed an acutely ill man, who was dyspneic and diaphoretic, with a blood pressure of 148/98 mm Hg and a rhythmic pulse of 180/minute. The neck veins were full at 20°; there were fine râles over both lung bases and a short, Grade II apical systolic murmur, no gallop or rub, no peripheral edema, and no hepatomegaly. Laboratory examinations provided blood counts, sedimentation rates and enzyme studies compatible with acute myocardial infarction. There was history of a posterior myocardial infarction in 1948 and paroxysmal atrial fibrillation in 1964. The patient had drunk and smoked excessively prior to 1948, but has since stopped smoking and greatly reduced the alcohol intake. He alleged that he had been on digoxin, diuretics, and nitroglycerin intermittently since the 1964 episode. The family history is noncontributory.

During the first five days in the hospital there was persistent ventricular tachycardia despite attempts at conversion with quinidine and procainamide (Pronestyl). On Feb. 4 he was treated with the direct-current defibrillator in the cardiac monitoring room, after preparation with thiopental (Pentothal) and succinylcholine (Anectine). There was immediate conversion to a nodal rhythm at a rate of 75–80/minute, but assisted respiration was required for a while because of excessive action of the succinylcholine. The cholinesterase content of the blood was reported by the laboratory at that time to be low normal. Following this episode the course has been uncomplicated; presently the patient is up and about, free of pain, and feeling well.

Dr. Mountain: Doctor Darien, you admitted this man. Will you give us your experience in the case?

Dr. Gholi Darien: I was not familiar with the patient until called to see him in the hospital. The EKG revealing apparent ventricular tachycardia, I tried to convert him with quinidine, persisting until 2 a.m. without success. When Doctor Rosenbaum saw him that morning he continued the quinidine, but still without conversion. It was amazing to us how long the patient persisted in ventricular tachycardia without going into failure.

Dr. Mountain: Had he been digitalized?

Dr. Darien: He said on admission that he had been taking 0.25 mg of digoxin every morning.

A Physician: Two questions. Has the cardiac output decreased as the result of the ventricular tachycardia? And is he being maintained on anti-arrhythmic drugs?

Dr. Darien: During the first day the blood pressure was taken every half-hour and ranged between 126 and 160 systolic over 90 and 120 diastolic. At present it is between 140 and 150/90. Further, except for one brief period, there was no clinical evidence of cardiac failure. He is still being treated with digitalis and quinidine.

Dr. Mountain: Doctor Rosenbaum will now discuss some of the diagnostic and therapeutic aspects of ventricular tachycardia that are relevant to this case.

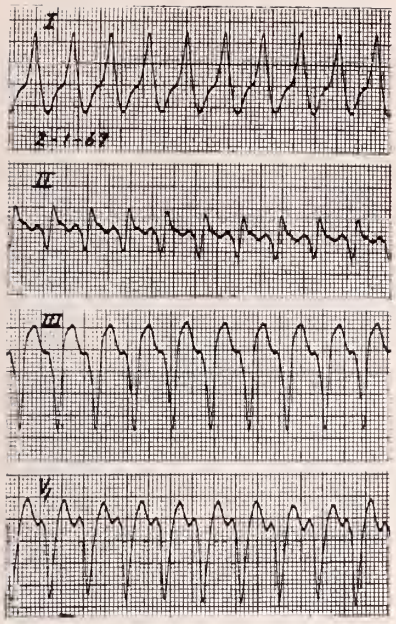

Fig. 1—Feb. 1, 1967. Paroxysmal ventricular tachycardia.

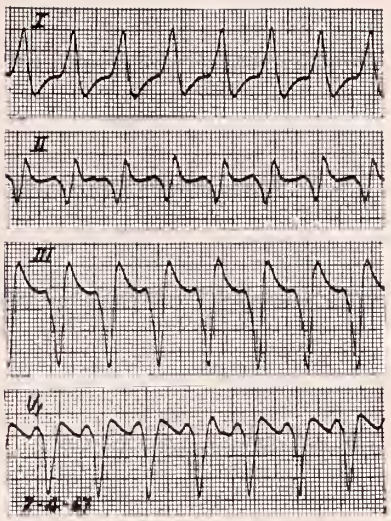

Fig. 2—Feb. 4, 1967. Paroxysmal ventricular tachycardia. Note slower rate due to quinidine. Immediately prior to D–C cardioversion.

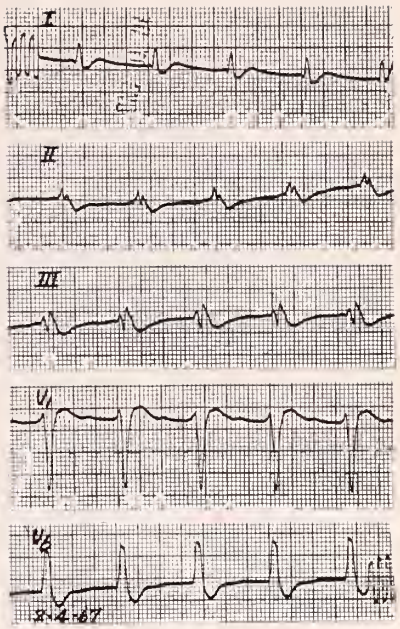

Fig. 3—Feb. 4, 1967. Probable atrioventricular nodal rhythm. Immediately after D–C cardioversion.

Dr. Francis F. Rosenbaum: The problems were posed by the facts that we had no accurate history because the patient had been unknown to the attending physician prior to admission, and we were not really certain that he now had ventricular tachycardia, or how much digitalis he had been taking. Consequently we did not turn immediately to direct-current defibrillation, for we may have been dealing with a supraventricular tachycardia with either aberration of the ventricular responses or a fixed intraventricular block. Still further, were we dealing with a case of digitalis intoxication? I think there is little doubt that this patient has extensive coronary artery disease, but I am not convinced that a fresh infarction initiated the arrhythmia with which we were dealing.

In the first tracing (Fig 1), and that made immediately prior to conversion (Fig 2), we see a grossly abnormal EKG with perfectly regular ventricular rhythm but without evidence of independent auricular activity. There may be auricular fibrillation, auricular flutter or auricular tachycardia, or the auricles could be responding to the ventricles in a 1 to 1 or some other ratio. The next tracing (Fig 3) is the first one made after the defibrillation, and again there is nothing that looks like auricular activity; I suspect there is a nodal rhythm with the auricular complexes superimposed upon the QRS complexes. The QRS complexes have changed but are still quite broad, and the heart rate is now 85/minute; I believe there is now a different interventricular conduction defect than that which we had earlier. Now in the next tracing (Fig 4a), which was made four days after the conversion, we see clearly that he has auricular tachycardia with 2 to 1 AV block. Then in this, the latest and last tracing I shall show (Fig 4b), normal sinus

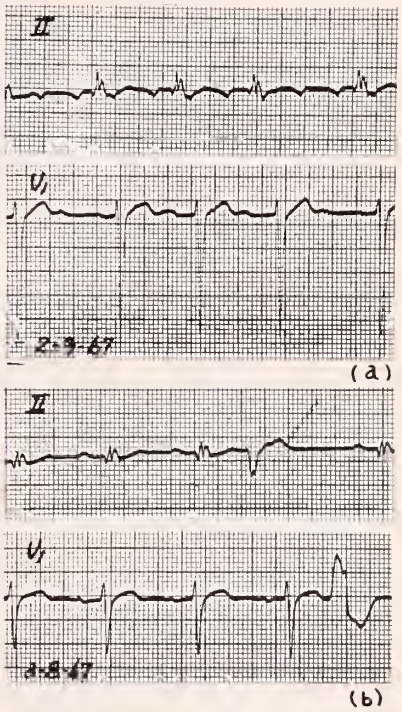

Fig. 4a—Upper two records taken on Feb. 9, 1967, show supraventricular tachycardia with atrioventricular block.

Fig. 4b—Lower two records on Mar. 8, 1967, show normal sinus rhythm with occasional ventricular premature beats.

rhythm is present but you can see that premature ventricular contractions are beginning to appear, sometimes actually giving rise to bigeminy, and one can suspect that this particular person is subject to the type of arrhythmia which he originally presented on admission.

Ventricular tachycardia, a regular rapid rhythm, arising from a ventricular ectopic focus or from a ring of ventricular conducting tissue, may occur in brief salvos of beats or be continuous for days and weeks; the longest-lasting I have seen was about 4 weeks, but there is record of 103 days, with recovery. The heart rate is usually between 150 and 220, the more rapid rates tending to occur in younger individuals. The auricles and ventricles are usually beating at their own independent rates, but when this is not certainly the case we have diagnostic, and thus naturally, therapeutic difficulties. There may be auricular fibrillation or flutter or tachycardia. The auricles may be responding by retrograde activation from the ventricles, with a 2 or 3 or 4 to 1 response, or there may be actual auricular standstill. In the latter case we would strongly suspect severe digitalis intoxication. And then sometimes in ventricular tachycardia the ventricular rate may be as slow as 70 to 140 beats/minute, when there is a parasystolic focus. Actually in ventricular tachycardia the tracing is not much more than a succession of ventricular premature beats with broad and bizarre QRS complexes. It helps very much in establishing the diagnosis from the EKGs to be able to demonstrate independent auricular beating, and of course if one can record the beginning of the paroxysm, as is feasible in an intensive coronary care unit, the diagnosis becomes relatively easy. It is the patient of the type we have under discussion this morning that gives us trouble. a rapid rate with ventricular conduction broken down so that the QRS complexes are abnormal and there is no clear indication of what the auricles are doing.

Classically, ventricular tachycardia occurs as a complication of acute myocardial infarction, but it is also one of the mechanisms of Adams–Stokes seizures; many of the episodes in these patients are due to ventricular tachycardia. We have had patients with Adams–Stokes attacks who sometimes had a ventricular standstill and at other times had ventricular tachycardia. Digitalis in excessive dosage is prone to cause ventricular tachycardia, but quinidine, procainamide, potassium, and a number of other agents can do it. In our patient this morning there was confusion regarding the exact amount of digitalis he had been taking, and this contributed to our dilemma. Epinephrine given a patient under cyclopropane or chloroform anesthesia may cause ventricular tachycardia, and exercise will do it in a small group of individuals; and direct-current defibrillation may induce it in a patient who has auricular fibrillation, in whom the amount of digitalis he was receiving proves suddenly to be a toxic dose after conversion to a normal rhythm. One should omit digitalis for 24 to 48 hours, as we did in this patient, before attempting direct-current conversion.

Helpful points in bedside diagnosis of ventricular tachycardia: (a) Listen very carefully to the first heart sound at the apex; there may be a superimposition of the auricular on the ventricular sound so that every sixth or eighth beat will be sharper, snappier, and louder. This was unfortunately not true in this morning's patient. (b) In the neck you may see from time to time very large A waves ("cannon" waves) at a slower than apical rate, due to an auricular systole at a time when the tricuspid valve is closed. (c) Carotid sinus pressure and other methods of vagus stimulation are completely ineffective.

As to remedial measures other than direct-current defibrillation, let me say that procainamide (Pronestyl) is best given as 3.0 gm in 250 ml of 5% dextrose in water at the rate of 100 mg/minute for 1 minute and the rest at half this rate, discontinuing temporarily if the QRS complex widens more than 50% for 20 to 30 beats; and have levarterenol (Levophed), 2 mg in 500 ml of the dextrose solution, on the other arm of a Y-tube setup to counteract the possibly induced hypotension. Intramuscular procainamide dosage: 1.0 gm every 2 to 4 hours; oral, 1.0 gm and repeat in 2 hours, then 0.5 to 1.0 gm every 4 to 6 hours. Lidocaine (Xylocaine) is said not to cause hypotension, but the effect may last only 10 to 20 minutes. This drug is commonly used to control runs of premature ventricular contraction in acute situations; 1–2 mg/kg (50–150 mg in the adult) intravenously in 1 to 2 minutes and repeat once or twice at 20 minute intervals if necessary. Quinidine gluconate intravenous dosage is up to 0.8 gm diluted in 50–

150 ml of 5% dextrose in water, given during 30 to 60 minutes; intramuscular dosage, 0.4–0.8 gm every 2 hours; monitor EKG for block while giving this drug and watch the blood pressure.

Dr. Mountain (summarizing): Our patient this morning presented the sort of problem that taxes both one's acumen and patience: a life-threatening arrhythmia that is indistinctly defined. Was this truly ventricular tachycardia, and if so was it digitalis-induced? Was the irregularity superimposed upon a recent acute myocardial infarction? How should the patient be treated? I think that these questions have been succinctly dealt with in the discussion.

WISCONSIN'S HEALTH

by E. H. JORRIS, M.D., State Health Officer

PUBLICATION REPORTS POISONINGS IN STATE

The publication "Accidental Poisoning in Wisconsin," which is compiled by the Statistical Services Division of the State Board of Health, has now been distributed. This report covers poisoning deaths for the 5-year period 1961–1965 and accidental poisoning cases reported in the 1963–1965 period.

A compelling indicator of the need for constant awareness of the problem of poisoning is the record for the year 1965, when 237 deaths due to poison were registered in Wisconsin. This includes 93 deaths due to accidental poisoning and 144 attributed to suicidal poisonings. If distributed evenly throughout the year, the average would be more than four deaths per week.

The current report includes for the first time a table giving the number of suicidal poisoning deaths. The compilers note that for both accidental and suicidal deaths from poisoning the rates for the divorced segment of the population are much higher than among other groups. This suggests that an unknown number of fatal poisonings listed as accidents are actually suicides. If a poisoning is not clearly listed as suicide it is coded as an accident.

Accidental poisoning deaths are divided into two general categories that show 56.6% due to gases and vapors and 43.4% caused by solid and liquid substances. More than half of the deaths due to gases and vapors are from motor exhaust gas and more than half of those due to solid and liquid substances are from analgesic and soporific drugs, such as pain and sleeping pills.

As an aid in identifying the scope of the poison problem in Wisconsin the second section of this volume may be of greater value than the death figures that constitute Part I. The second section is data on the 11,243 poison cases treated in the emergency rooms of 53 hospitals throughout the state during the 3-year period of 1963–1965. Participating hospitals send reports of each case to the State Dept. of Health and Social Services.

More than 60% of all poison cases reported are from internal medicine and over half of these cases involved aspirin.

Almost three-fourths of the cases of accidental poisoning reported in 1963–1965 are among children below the age of 4. Age 2 is the worst single age and accounts for nearly one-third of all cases reported.

Approximately half of our state's population is served by the 53 hospitals that submit poison reports, so it is reasonable to assume that the number would double if all hospitals were reporting. The total then would still exclude the many cases treated in clinics and in the private offices of physicians, as well as those that never receive professional medical attention. It is obvious that poisoning in general is a sizeable public health problem in Wisconsin.

ORGANIZATION FORMED FOR WISCONSIN EPILEPTICS

Wisconsin was the first state to permit the issuance of driving licenses to persons who are epileptics. That law, passed in 1949, was the forerunner of similar legislation in most of the other states and constituted a stride toward better public understanding of the nature of epilepsy.

In the spring of 1966, at the request of Gov. Warren Knowles, the State Board of Health established an Advisory Committee on Epilepsy to consider the problem of epilepsy in Wisconsin, assess the needs and make recommendations to meet them. The committee was headed by Dr. Francis M. Forster of the University of Wisconsin, Madison. Members were: Dr. Jean Davis, Milwaukee; Prof. Nathan Feinsinger, Dr. Leonard Ganzer, Don Johns, Carl Mayer, Dr. Frank Reider, Hugh Russell, Dr. Horace Tenney III, John Thompson, Adrian Towne, all of Madison; Dr. Francis Kruse, Jr., Marshfield; Dr. Philip White, Milwaukee.

The committee found: (1) The incidence of epilepsy is sufficiently high in Wisconsin to be a socio-economic problem. (2) There is need in the state for additional epilepsy clinics to supplement the four presently in existence. (3) There should be a better awareness of the potentialities of the services for epileptics through professional education as well as better information about epilepsy directed to the public and ancillary and paramedical personnel. (4) Further consideration should be given to the laws affecting epileptics.

In February of this year the Wisconsin Epilepsy Association was incorporated as a voluntary organization. Incorporators of the association are seeking statewide representation for its board of directors and are developing a comprehensive program that will give the people of our state better understanding of epilepsy in Wisconsin.

THE PRESIDENT'S PAGE

HAROLD J. KIEF, M.D.

SMS means aggressive leadership

Red Alert

■ ABOUT EVERY THREE SECONDS someone is disabled in a traffic accident! This means 1,200 victims every hour or 28,800 traffic injuries every single day. In 1966, 1,119 men, women, and children died on Wisconsin highways. Your State Medical Society is keenly aware of this daily carnage and firmly believes that it has a primary responsibility not only in patient care but also in education and research, thus assuring the highest standards of patient care. But more than this, we, as physicians, must give stimulus guidance and leadership to the public, to our community, and to our state legislature in developing programs and methods designed to prevent this wasteful suffering and death.

In October, during Wisconsin's Work Week of Health, an entire day was devoted to traffic safety. Furthermore, two of the major commissions of your State Society—Commission on Hospital Relations and Medical Education and Commission on Safe Transportation—are currently engaged in surveying, studying, and drafting minimal medical standards that, when adopted, will certainly help prevent deaths on the highways. Your Society is working with federal and state administrators in developing these guidelines.

Little has been written about the Federal Highway Safety Act of 1966. This federal law actually has two components: the first outlines government-imposed standards of safety for new vehicles and the second places directly the full responsibility of highway safety upon the governor of each respective state. Unless the respective legislature and governor of each state develops minimum standards for highway safety by 1968, the individual states will lose ten per cent of all highway aids. Eight minimum standards have already been promulgated under the title, "Emergency Medical Service," by the United States Department of Commerce.

It is the duty of the doctors, as citizens and as physicians, to help their State Medical Society and their legislative representatives to pass enabling legislation that will be medically sound and financially practical to help solve the problem of accidental deaths. The 53,000 accidental vehicular deaths in these United States in 1966 represents a total waste of life! The responsibility of this waste must be equally shared by the driving public, the physicians, and the legislature.

This is why the State Medical Society is now on a "red alert" to give leadership and guidance in highway safety programs and in emergency room standards. You, as physicians, can be of service to your patients by quickly surveying your community and its needs and then giving this information to the Society commissions studing this subject. Furthermore, let your legislators know of your urgent concern for a more adequate highway safety program.

H J Kief MD

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EDITORIALS

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The Total Drop-out

■ THE ARTICLE BY Dr. Carl I. Wold appearing in this issue of the *Wisconsin Medical Journal* entitled "Social and Medical Responsibility in Suicide Prevention" underlines the growing need for physicians to face up to their role in the emotional climate of the potentially suicidal patient. With suicides occurring at an annual rate of 25,000, and increasing, medical personnel have a clear obligation to intervene, not only by the sensitive recognition of prodromal symptoms but also through the establishment of mechanisms to handle the suicidal crisis.

Doctor Wold's article describes some of the symptoms displayed by the suicidal patient. The physician should be alert to these signals; he should always maintain an awareness of a final and fatal solution to the patient's emotional and physical problems. There should be no hesitancy in engaging the patient in an honest discussion on whether he intends to kill himself. As Doctor Wold points out, there is no evidence that such discussion has ever planted an idea of suicide that didn't exist before. The direct approach often reaches to the heart of the matter quickly, establishes the physician's concern for the patient as a human being, and opens a vital channel of communication.

But the influence that a physician can have on the patient's decision—if indeed it is a decision—of whether it is better to live or die is limited. The modalities of medicine relate only to part of the life process. The presence or absence of spiritual values colors the world outlook and conditions the patient's attitude toward living and dying. In this area religious help is indicated, and most clergymen are quick to react in the presence of the crisis. The trick is to prepare for cooperation before the crisis occurs. Medical personnel should take the initiative in instituting discussions and seminars with local clergy groups so that everyone has a clear understanding of the symptoms that portend suicide. Perceptive observation and sympathetic approach can probably do much to reduce the incidence of suicides when the problem is attacked cooperatively—body and soul.

Every county medical society in Wisconsin should take notice of the growing number of "crisis service centers" already established in the United States. While most are

in large metropolitan areas where the concentration of population produces a greater frequency of suicide, they could be useful everywhere in connection with the usual emergency room service. A study of these centers could produce a valuable blueprint for the implementation of a life-saving facility uniquely adapted to local environment.

Doctor Wold points out that suicide most often results from a failure of hope at various crises in human life. To the stable, well-oriented person hope is self-renewing, springing from the richness and the infinite variety of life. The responsibility of the physician in the prevention of suicide is to buy a little time to allow hope to issue forth again. To do this requires recognition of the potentially suicidal patient, a positive technique in approaching the problem, cooperation with clergymen, and a crisis service center to take action at the last minute. We can do no less than to rise to these responsibilities in a vigorous and productive manner.—DNG

Help Needed

RECENT NEWS FROM VIETNAM emphasizes the suffering among civilians. In a country almost naked of adequate medical institutions the ravages of modern warfare have been added to the usual prevalence of disease and effects of poverty. The unavoidable misery produced by military operations has placed an intolerable burden on the few health care facilities existing in the country.

To help supply the need for medical care for the Vietnamese, 320 American physicians have already offered their services through "Volunteer Physicians for Vietnam," a program administered by the American Medical Association and financed by the U.S. Agency for International Development. Each doctor who volunteers receives only his transportation to and from and within Vietnam, plus $10 per day for expenses. He serves in civilian hospitals and treats civilian patients; his role is humanitarian, without relevance to the military effort of the United States except that his presence expresses the compassion of the American people for suffering humanity.

As a result of the increasing need for medical personnel in Vietnam, the project has raised its recruitment goal from 192 physicians per year to 300. The plan is to send 50 doctors every two months in staggered contingents so that a full complement is in the country at all times.

Ten Wisconsin physicians have already responded to the call for volunteers: Drs. Thomas P. Chisholm, Arcadia; Victor S. Falk, Edgerton; William B. Gallagher, La Crosse; Samuel B. Harper, Madison; Charles E. Hopkins, Madison; Reynold E. Nesemann, Kewaunee; Joseph P. Springer, Durand; Leif H. Lokvam, Kenosha; Thomas J. Beno, Green Bay; and Isadore Schultz, Mazomanie. They are to be continuously congratulated for their dedication to the ideals of their profession and respected for this concrete demonstration of their altruism.

It is to be hoped that the fine example of these ten Wisconsin physicians will inspire others to volunteer for the program in 1968. Dr. Charles H. Moseley, director of the project for the AMA, has indicated a need for more surgeons, orthopedic surgeons, general practitioners, and internists. Interested MDs are asked to contact the AMA Department of International Health, 535 N. Dearborn St., Chicago, Ill. 60610.

It is reported that the doctors who have participated in the program have enjoyed a productive, worthwhile experience. The practice of medicine under relatively primitive conditions, with responsive patients and under terms of complete selflessness, seems to result in a refreshing emotional and spiritual elevation. Doctor Falk has returned to Vietnam for the second time.

Every doctor who is serious about his commitment to relieve human suffering has an obligation to consider seriously his ability to serve as a Volunteer Physician for Vietnam.—DNG

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Medical and Surgical Management of Coronary Disease

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■ THERE IS GOOD REASON to believe that recent advances in the diagnosis and treatment of coronary disease are showing promise of great improvement over the results obtainable in the past.

Reliable coronary arteriography makes it possible to free the patients who are believed to have the disease but actually do not from the psychologic and sociologic handicaps of a diagnosis of coronary sclerosis. Some of them have chronic myocarditis, which in general has a much better prognosis, and others have no heart disease at all.

Coronary arteriography also makes it possible to differentiate several other types of patients who could not be clearly distinguished in the past. Patients in the group with poor prognosis have severe constrictions threatening to cause future infarctions in additional regions of the myocardium. Patients are in a group with a better prognosis if the regions of myocardium that were threatened by sclerotic constrictions are already largely infarcted out with no other constrictions threatening future complications. Other patients have no sclerotic areas likely to get worse and have good prospects for the development of intercoronary collateral channels that will compensate for those constrictions that are present.

The use of nitrates for preventing myocardial infarction seems much more promising than anticoagulants.

An increasingly reliable operation is being developed for providing collateral channels to ischemic areas of the anterior, lateral, and/or posterior aspects of the left ventricle.

About 95% of the patients referred for management of coronary disease under this program are told either that they do not have coronary disease, or that they have coronary disease of the type that can be expected to do well on medical management, or that surgery is necessary and can be performed with expectation of success. Only about 5% are told that the coronary disease is too far advanced for medical or surgical treatment to be expected to be successful in the improvement of symptoms and in prevention of future infarctions for a period of many years.

CORONARY ARTERIOGRAPHY

The treatment used depends upon the findings in coronary arteriograms taken by the Sones technique.[1,2] Studies have shown that arteriograms can be expected to permit an accurate description of coronary disease or to rule it out with an accuracy of better than 98%,[3] but only if the technique and equipment recommended by Sones are used

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without compromise.[3,4] These requirements include selective individual catheterization of the right and left coronary arteries with filming in a 60° left anterior oblique position; injection of the left coronary in a flattened left anterior oblique, the PA, and the right anterior oblique; use of cinefluorographic apparatus with a 6″ image intensification tube, an overframing lens, and 35 mm film.

INDICATIONS FOR CORONARY ARTERIOGRAPHY

Diagnostic Problems

I do not believe that coronary arteriography is necessary to make a definite and accurate diagnosis of coronary disease if there has been an infarct proven by QRS changes, or if there is at least a 1.5 mm depression of a horizontal ST segment during exercise. However, arteriography is necessary under other conditions if we wish to be accurate in the approximately 10% of patients with typical angina who do not actually have coronary disease. The incidence of coronary disease in atypical angina varies widely but is perhaps 50%. Some of these patients, however, have very severe and dangerous coronary disease.

A Problem of Management

Arteriography is often very helpful in deciding whether to advise drastic revision of a patient's way of life, such as whether he should retire early or whether he can safely engage in occupational or recreational exertion. Recommendations to patients in this group should be very conservative if noninfarcted areas are threatened with severe constrictions that are likely to progress. The advice can be much more liberal if vulnerable areas are already largely infarcted out or sclerotic areas are already well compensated by intercoronary collateral arterial channels.

Surgical Candidates

A patient in this category is one who is free of clinical contraindications to surgery and who is sufficiently disabled by symptoms of coronary disease to be interested in a major operation. Also included are a few patients who are asymptomatic postinfarction but are sufficiently worried over the prospects of future infarctions or death to be willing to consider surgery. The most common clinical contraindications to surgery are age over 65, severe emphysema, severe valve disease, or general conditions that would increase the risk of thoracotomy significantly.

CONTRAINDICATIONS TO ARTERIOGRAPHY

Mason Sones has been heard to comment that coronary arteriography can be performed safely on any patient who can walk through the door and lie down on the table. In general these restrictions should probably be followed although occasionally arteriography has been done without difficulty on patients who were orthopneic or scarcely ambulatory. Additional relative contraindications to arteriography are frequent episodes of paroxysmal atrial tachycardia or ventricular tachycardia. Coronary arteriography has been performed within a few hours or a few days after major infarction but there is rarely a need to do it this soon. It certainly is not necessary for diagnosis under these conditions. Surgery is delayed for four months after a major infarction, and problems of occupational management do not come up for several months.

RISKS OF CORONARY ARTERIOGRAPHY

The mortality risk of coronary arteriography by the Sones technique is less than 1 per 1,000. So far, I have done 470 coronary arteriograms without fatality or major infarction.

The loss of the radial pulse is often fairly common during the learning stages, but has been under 1% of the most recent 400 cases. These patients with thrombosis of the brachial artery run minimal risk of gangrene but are very likely to have annoying claudication for many months.

Failure to get a complete study is the most likely risk to be faced by a patient undergoing coronary arteriography. It was very high in the early cases, but has been under 10% in the most recent 200 in the current series.

CORONARY ARTERIOGRAPHIC FINDINGS

Coronary arteriograms have been performed on a total of 470 patients. Unfortunately, only the records on the 198 performed at the Guthrie Clinic are available for detailed analysis. The findings are presented in Table 1.

TABLE 1—*Coronary arteriographic findings*

24	12%	Normal coronary arteries and no myocardial disease
18	9%	Normal coronary arteries and myocarditis
51	26%	Coronary sclerosis giving indications for medical but not surgical treatment
93	47%	Coronary sclerosis giving indications for surgery
7	4%	Such severe coronary sclerosis that surgery was contraindicated
5	2%	Inadequate arteriograms

MEDICAL MANAGEMENT

RATIONALE

The medical management is based on the belief that myocardial infarction is caused by coronary sclerosis and one of two additional events. In one of these, an increased need for cardiac output raises the requirements of the myocardium above the maximal amount of blood that can get past the coronary constriction. This produces a relative myocardial ischemia leading to necrosis and infarction. This is the less common cause of infarction.

By far the most common cause is spasm in the coronary distal to the sclerosis. These problems have been previously considered in some detail.[3,5]

THE MEDICAL REGIMEN

The Isordil Tembid is prescribed every morning or twice a day. This is a delayed release preparation of isosorbide dinitrate. It does not maintain maximal dilation of coronaries but seems to make spasm less likely and also seems to accelerate collateral development. Half of this dose is used for several weeks if headache is a problem initially.

The patients are also urged to carry sublingual Isordil and sublingual nitroglycerin with them at all times. The Isordil is to be taken promptly at the onset of any pain suspected of being myocardial in origin. If 5 mg sublingually every 2 hours is inadequate to control symptoms, then the patients are instructed to take at least one nitroglycerin every 10 minutes as long as symptoms persist. It is important that this medication be continued even though it does not appear to be relieving the pain initially.

INDICATIONS AND RESULTS

The above nitrate regimen is considered indicated for any patient who has a constriction reducing the lumen of a major coronary branch below 50% of normal. Constrictions in this range are capable of causing angina pectoris, myocardial infarction, or arrhythmic death. Many of these constrictions, however, seem to be asymptomatic.

So far 407 patient months of observation are available on 51 patients in this group who did not have sufficiently severe coronary constrictions to meet the indications for surgery, and are following this regimen. So far there have been no infarctions and no deaths.

The nitrate regimen cannot be expected to be entirely adequate for patients with sufficiently tight constrictions to meet the indications for surgery. Nevertheless, the drugs are helpful for this group also. Including cases from a previous series,[5] there have been a total of 1,122 patient months of observation accumulated by 209 patients, during which there was no possible protection from surgery. There were 6 nonfatal infarcts sufficiently severe to alter the QRS complex during this period. A total of 1,872 patient months were accumulated by them during which time there was or may have been protection from the pedicle operation. There were 2 infarctions in this group. A total of 40 to 80 infarcts would be expected during this same period of observation on patients with this much coronary disease who were treated with anticoagulants and relatively ineffective coronary vasodilating drugs.[3,5]

SURGICAL TREATMENT

EVALUATION OF RESULTS

Operations designed to give collateral channels to coronary arteries have been proposed for many years. Most of these have not been accepted by the medical profession as being of significant value. The skeptics turned out to be wise because the vast majority of these operations actually were of no detectable value. The problem arose because of the lack of a satisfactory objective method for demonstrating whether or not collateral channels actually did develop to the coronary arteries. Although some "observers" apparently can see no difference between the surgery done today and the Beck I operation or internal mammary ligation, there actually is a highly significant difference. This difference lies in the advent

of a valid and satisfactory objective method for evaluating the extent of this collateral development.

Several objective methods are being presented today. Unfortunately, not all lead to reliable and sound conclusions, but should be considered carefully in order to avoid confusion and erroneous conclusions. The major methods being advocated today are:

(1) Clinical Results

These results are important and a good clinical result after surgery for coronary disease is definite and profound. An observer who has seen a number of such patients can easily compare one with another. Unfortunately, there is no satisfactory method for documenting this improvement and, therefore, results obtained by one observer cannot be compared with those obtained by another. This point has been dramatically emphasized by the fiasco of the internal mammary ligation operation.[3]

(2) Demonstration of Collateral Channels in Autopsy Specimens

As has been previously demonstrated,[3] it is quite possible to fill a large amount of the coronary arterial system through collaterals that are much too small to carry significant quantities of blood during life if the injection is done after death. An operation, therefore, which can be demonstrated only by postmortem injections to give collaterals to the coronary arterial circulation should not be considered successful.

(3) Patency Rates of Implants

Although patency of an implant is a necessity for success, it alone is insufficient for the operation to be considered successful.[3,6]

(4) Cinearteriographic Coronary Arterial and Venous Filling

It is quite possible to force more radiopaque medium through collaterals than would otherwise be carried by the blood. However, cinearteriography done by a selective injection of the implant with a catheter that does not completely occlude the vessel is a valid method for demonstrating the location, size, and number of collateral channels, the direction and velocity of movement through them, and the destination of this blood.[3,6]

(5) Metabolic Studies

Since we know that myocardial ischemia is the result of inadequate arterial supply to the myocardium, it seems logical to assume that the heart would be improved by providing additional arterial supply to this area. However, criticis in the past have pointed out that arteriographic filling of coronary arteries through collateral channels from an implant does not in itself prove that the myocardial metabolism has been improved. Fortunately, careful and detailed studies by Gorlin and his group[7] have shown that sufficient collateral to give good coronary arterial filling in a selective mammary arteriogram does reverse an ischemic pattern of lactate metabolism to normal. A continuation of this work has shown that implants which are patent but do not give good collateral do not cause detectable changes in the ischemic metabolism.

Conclusion

These considerations are interpreted as indicating that good coronary filling from a selective mammary cinearteriogram is necessary in order to claim objective demonstration of a good result after an internal mammary implant. I believe that such a demonstration is a necessity and is sufficient, admitting freely that some critics will consider an operation worthwhile even though such coronary filling has not been demonstrated, and that other critics remain unconvinced that the surgery has accomplished anything even though such demonstration is offered.

CHOICE OF PROCEDURE

Direct Attack

Although I previously presented an opinion[3] in agreement with Effler when he said that endarterotomy and patchgraft was the procedure of choice for constrictions of the left main coronary, I am forced to accept his present loss of enthusiasm over this approach. So far, there is no reason to believe that coronary endarterectomy is more satisfactory than Effler's operation under any circumstances.

Mammary Implants

There is now general agreement among those doing surgery for coronary disease on the choice of the internal mammary artery for myocardial ischemia. There does remain some disagreement over the technique for implantation.

Vineberg has presented clinical results, autopsy injections, and patency rates after the Vineberg mammary implant but so far

has not published the incidence of good coronary filling from mammary arteriograms.[8] Bigelow[9] reported such filling in 8 (31%) of 26 mammary arteriograms. This can be compared with an incidence of over 90% with the pedicle.[6]

Secondary Areas

Free vein grafts,[10] fat, and epicardectomy[8] are being used to give arterial supply to areas of the myocardium unlikely to be supplied by a single mammary implant. So far there has been no evidence presented showing collateral carrying blood to the coronary arterial system.

The gastro-epiploic artery has been proposed for the diaphragmatic aspect of the heart.[11] There has been demonstration of coronary arterial filling through collateral from these implants, and this procedure merits serious consideration.

Implantation of both the right and left mammary arteries by a slightly modified pedicle technique has been reported.[12] This operation is based on sound theoretical concepts, and very probably will be demonstrated to give a high incidence of good coronary arterial filling.

A triple pedicle has been proposed[3,6] and seems to me to be the most promising of the procedures for providing collateral to multiple aspects of the heart. This procedure has the advantage of permitting three implants in any desired combination of regions of the left ventricle, and can be done without entering the abdomen. As will be presented below, this operation has given a higher incidence of good coronary filling to multiple aspects of the ventricle than has been reported for any of the other procedures so far.

INDICATIONS FOR THE PEDICLE

There definitely is no demand for collateral[3] unless the lumen of all major coronary branches to an aspect of the left ventricle is reduced to less than ¼ normal at some point. Unless demand for collateral is present, certainly none will be obtained and the operation would be most ill advised.

The left ventricle is considered to consist of anterior, lateral, and posterior areas. Demand is considered to exist in an area if all or nearly all of the viable myocardium is nourished by blood obstructed by such constrictions without well developed intercoronary collateral channels around them.

The pedicle operation is advised for all patients free of contraindications who have such demand in two or more aspects of the left ventricle whether or not symptoms are present. Surgery is advised for a single area only if symptoms are present and if the constriction is in a location not likely to be bypassed by the development of intercoronary collateral vessels.

CONTRAINDICATIONS

The pedicle is considered contraindicated for patients with an estimated physiologic age above about 65. An absolute contraindication is the existence of triple disease and a left ventricular end diastolic pressure above 14 mm Hg. Triple disease is herein defined as constrictions leaving less than ¼ normal diameter still open in all three aspects of the left ventricle. Patients with triple disease are accepted for surgery if the end diastolic pressure is normal, and those with high pressure but less than triple disease are also acceptable. Clinical contraindications to thoracotomy include emphysema, serious valvular disease, refractory congestive failure, and dangerous arrhythmias.

THE TRIPLE PEDICLE TECHNIQUE

The technique for this operation has been described in some detail.[3] In general, the pedicle is made from the internal mammary artery, vein, adjacent connective tissue, and muscle. It also includes two intercostal arteries and veins. In the current technique, the distal 1.5 cm of the artery is dissected free and a single hole is made in the portion to be implanted in the tunnel. The hole is carefully positioned so that it will end up as close as possible to the coronary branch which passes over the tunnel, which is incised in the myocardium with a blade. A 0.5 cm tongue of muscle is placed in the tunnel along with the vessel (Fig 1).

Limbs of the triple pedicle can be implanted in the anterior, lateral, or posterior aspects of the left ventricle. Usually if surgery is needed at all, there is severe ischemia in two or three areas of the ventricle. Ischemia of a single area is very rare in patients with symptomatic coronary disease. Most of the patients with disease in two areas still profit from three implants because past or future progression of sclerosis often disconnects two or more major branches within the same area.

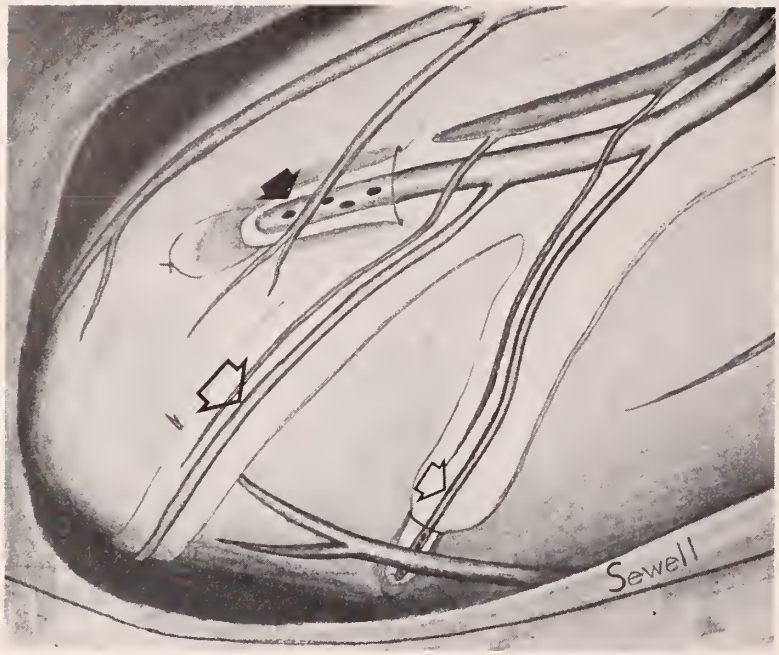

Fig. 1—Diagram of a triple pedicle in place. The mammary limb (solid arrow) has been placed under a distal anterolateral branch of the anterior descending coronary artery. The 6th intercostal (large open arrow) passes around the apex and has been implanted under the posterior descending artery (not shown). The 5th intercostal artery (small open arrow) is placed under the left marginal. The positions can be varied considerably, depending upon the location of the ischemic areas.

Fig. 2—A single frame from a selective mammary cinearteriogram taken one year postoperatively. When viewed in motion, medium can be followed down the mammary where it is still attached to the sternum (large open arrows). The mammary turns to the left and upward as it leaves the sternum and becomes pedicle (small open arrow). It curves laterally and downward (small open arrows). The medium then passes through a collateral artery and retrogradely up the diagonal branch (small solid arrows). It passes up the anterior descending to the point of occlusion of the left main coronary (asterisk). From here it goes down the anterior descending and laterally down the circumflex (large solid arrows). The left main coronary was open but constricted at the time of the preoperative arteriogram. Left Anterior Oblique Projection.

RESULTS

Operative Mortality

An operative mortality is defined as failure of a patient to be discharged alive for any reason after a pedicle operation. The retrospective operative mortality in patients with triple disease and elevated end diastolic pressure was 7 of 8 (87%). The operative mortality for all other patients has been 7 (3.4%) of 208 patients.

The First Year Postoperative Mortality

This postoperative mortality is defined as a death between the time of discharge from the hospital at completion of the pedicle admission and the time of the mammary arteriogram, which was usually performed one year postoperatively. Of 202 patients who survived the operation, 13 died during the first six months postoperatively. There were 160 who survived these six months, but 6 of them died between the sixth and twelfth

Fig. 3—Single frame from a selective mammary arteriogram done one year postoperatively, showing medium coming down the mammary (large open arrow), and into the 6th intercostal artery (medium open arrow). It passes through collateral into the posterior descending artery (small open arrow). This artery fills retrogradely to the solid arrow. PA Projection.

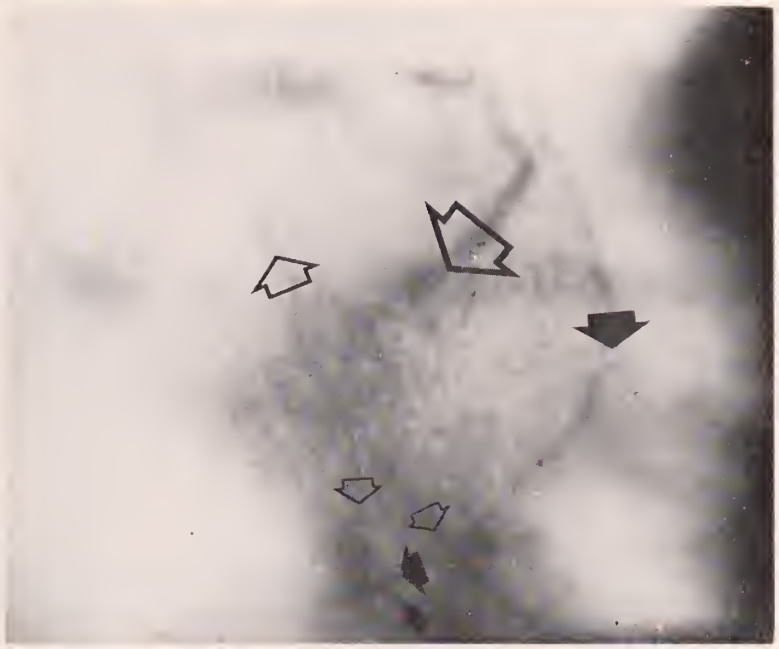

Fig. 4—An arteriogram showing function of both the mammary and intercostal limbs of a pedicle. The medium can be followed down the mammary (large open arrow) and through collateral into the anterior descending. It refluxes retrogradely (medium open arrow) and distally (small open arrows). The intercostal limb (large solid arrow) can be followed to a left posterolateral branch which fills retrogradely (small solid arrows). PA Projection.

months. (These figures do not add up to 202 because of 23 patients still living who have not yet completed this six-month period). There were 125 patients who survived the first postoperative year. One of these died before the mammary arteriogram was done.

TABLE 2—*Criteria for collateral development*

0	Mammary Occluded
1+	Mammary Patent Only
2+	Opacification of Small Coronary Arteries
3+	Opacification of Large Coronary Arteries
4+	Faint Venous Opacification
5+	Dense Venous Opacification

MAMMARY ARTERIOGRAPHIC RESULTS

Selective mammary arteriography was done approximately one year postoperatively on 123 of the 125 patients who survived that long. The arteriographic technique has been presented in detail.[3]

The arteriographic findings were rated according to Table 2. The total rating for a multiple pedicle was obtained by adding the

TABLE 3—*Mammary Arteriographic Findings*

	0	1+	2+	3+	4+	5+	6+	7+	8+	9+	10+	11+	12+	13+	Total Pts.
Single Pedicles	–	5	14	7	17	22	–	–	3	1	–	–	–	–	69
Double Pedicles	–	–	–	4	2	2	5	2	3	1	6	–	–	–	25
Triple Pedicles	–	–	1	–	–	–	3	1	2	1	–	2	2	1	13

*See Table 2 for mammary arteriographic rating scale.
Ratings for each limb of a triple pedicle are added together for each patient so that the theoretical maximum for a triple pedicle is 15.

rating of the limbs together. Examples are shown in Figures 2, 3, and 4.

Of the arteriographic series, 5 of the arteriograms were technically unsatisfactory. Eleven were done on patients retrospectively considered not to have had demand for collateral in the area of the implant, either because they were done before criteria for demand were accurately established or because of errors resulting from the use of a 9″ image intensification tube on the cine apparatus. This leaves 107 patients suitable for analysis.

Of these, 69 were done on patients who had single pedicles. Table 3 shows that 71% of the patients in this group had a rating of 3+ or more which is considered the minimum requirement for arteriographic success of the operation. Successful collateral to at least one area was obtained in 95% of the patients with multiple pedicles. It was obtained in two or more areas in 76% of the patients that had demand for collateral in two or more areas.

LATE CORONARY MORTALITY

After the mammary arteriogram was obtained, patients were rated according to the amount of collateral demonstrated. The coronary deaths in patients so rated is shown in Table 4. Although the series is still too small for true statistical significance, we can safely say that a trend is established and that a patient has a better chance of remaining alive if his coronary arteriographic findings are good.

TABLE 4—*Late Coronary Mortality*

Mammary Arteriographic Results	Deaths/Pts.	Deaths/Pt. Months Since Arteriogram	Pt. Months/Death
0, 1+	2/8	2/149	74
2+	2/17	2/254	127
3+ or More (Singles)	6/59	6/991	165
5+ or More (Multiples)	0/23	0/139	------

CLINICAL RESULTS

The clinical result is important to the patient and to the physician who cares for him. As presented above, such results cannot be used to compare operations or to compare patients evaluated by different observers. The placebo effect of surgery for coronary disease is real but usually can be easily distinguished from benefit resulting from the development of collateral channels. The psychologic effect comes on promptly postoperatively. It may persist or wear off but does not increase as time goes on. The physiologic effect does not begin for about two months and gives a progressive decrease in angina in relationship to activity as time goes on. Improvement usually continues for 6 to 18 months.

In general, patients with a good mammary arteriographic result can expect a good clinical result. However, divergence can occur for several reasons. Progression of the coronary disease can neutralize the benefits of good collateral development from the pedicle. On the other hand, development of a spontaneous intercoronary collateral channel can give benefit erroneously attributed to a nonfunctioning pedicle. Furthermore, some patients are embarrassed to admit a poor result or are afraid to admit a good result if there is financial incentive to remain disabled.

DISCUSSION

Medication for removal of coronary sclerosis or at least prevention of it would seem to me to be a far preferable solution to the problem caused by coronary disease.

However, several decades will very probably be required before this goal can be achieved. In my opinion, dietary and other measures for control of coronary sclerosis so far have been far from adequate in preventing symptoms and complications of this disease. However, there does seem to be a good chance that the morbidity and mortality from coronary disease in patients under 65 years of age can be improved considerably by the approach herein presented.

SUMMARY

The treatment of patients with coronary disease is based on the severity of sclerosis demonstrated by Sones type of coronary artriography. In the current series 42 of 198 patients were found to have no significant coronary sclerosis, even though all had a previous diagnosis or strong suspicion of this disease. Eighteen of these patients turned out to have myocarditis.

Patients with constrictions leaving between ½ and ¼ of the normal lumen diameter still open are placed on the nitrate regimen. So far there have been no deaths or infarcts during 407 patient months of observation on the 51 patients in this series. There were 8 nonfatal infarctions during 2,994 patient months of observations on 209 patients with constrictions leaving less than ¼ normal diameter still open, as compared to an expected incidence of 40 to 80 infarcts.

A pedicle made from the internal mammary artery, vein, connective tissue, and muscle, and sometimes also intercostal arteries, has been implanted in the left ventricle of 216 patients who had coronary constrictions leaving less than ¼ normal diameter open. The operative mortality was 3.4% of the 208 patients meeting current indications for surgery.

Implantations for myocardial ischemia cannot be soundly evaluated by improvement in angina, injections on dead hearts, or the patency rate of the implants. A good result can be claimed only if there is sufficient collateral to give good coronary opacification in a selective mammary cinearteriogram. Metabolic studies have shown that a good result by this criteria can be expected to reverse abnormal lactate metabolism to normal.

Such collateral was found in 71% of the patients after single pedicles, and 95% of the patients who had multiple implants.

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A brief story of how the human body resists infection and an outline of the immunizations currently available are provided in IMMUNIZATION FOR ALL, a new Public Affairs Pamphlet by Jules Saltman. It is available for 25 cents from the Public Affairs Committee, 381 Park Avenue South, New York, N. Y. 10016.

CASE REPORT

Cylindroma of the Trachea

By JOHN G. JAEGER, Madison, Wisconsin; JOHN F. BROWN, M.D. and GEORGE F. PRATT, M.D., Rhinelander, Wisconsin

■ PRIMARY TUMORS of the trachea are rare. The majority of tracheal tumors are malignant with the squamous cell carcinoma being at the head of the list.[1,2] The next most common primary tracheal tumor is the cylindroma. A case of a cylindroma of the trachea is presented.

CASE REPORT

A 74-year-old white man developed a choking sensation, intermittent dyspnea, and wheezing about three weeks prior to admission. He also complained of cough productive of mucoid sputum. One week before admission, on examination in the office, he had mild stridor. Indirect laryngoscopy and a chest x-ray film were negative. He failed to improve while taking expectorants and was admitted to the hospital on Nov. 8, 1966. He gave a history of hypertension and a mild stroke.

A physical examination revealed an active elderly man who had moderate stridor. His blood pressure was 200/95 mm Hg. Breath sounds were generally diminished. There was a hard nodule in the right lobe of the prostate. Chest x-ray and barium swallow films were negative. Planograms of the neck done in the AP and lateral projections showed a soft tissue mass measuring 2 x 1.5 cm within the trachea a short distance below the larynx (Fig 1). This mass appeared to be attached to the anterior wall of the trachea by a pedicle so that removal of the tumor with a segment of trachea seemed feasible. On Nov. 14, 1966, the trachea was exposed through an anterior incision. The trachea was opened in the midline and the incision had to be extended upward to the cricoid before the tumor was visualized (Fig 2). The tumor was found to be higher than expected and was attached to the surface of the cricoid cartilage and upper first tracheal ring. The tumor was removed locally and the base of the tumor was treated with electrodessication. There was no gross evidence of local spread. Frozen and permanent histopathologic sections of the tumor revealed it to be a cylindroma (Fig 3). A tracheostomy tube was inserted and removed in a few days. The patient recovered rapidly and was relieved of his symptoms.

Mr. Jaeger was a senior medical student at the University of Wisconsin Medical School and served his preceptorship with the Bump Medical Group at Rhinelander. He currently is interning at Lutheran Hospital, La Crosse.

Doctor Pratt is a general surgeon and Doctor Brown is an internist of the Bump Medical Group.

Reprint requests to: George Pratt, M.D., 617 Lake Shore Drive, Rhinelander, Wis. 54501.

On Jan. 16, 1967, a bilateral orchiectomy was done because of the carcinoma of the prostate. At the same time, the larynx and upper trachea were visualized through an anterior commissure laryngoscope. A generous punch biopsy at the tumor site showed a granulation tissue with no evidence of

A

B

Fig. 1—Planograms of the neck done in the AP (A) and lateral (B) projections show a soft tissue mass within the trachea immediately below the larynx.

cylindroma. Because of his age and general condition, more radical surgery will not be advised unless he develops evidence of recurrence of the lesion.

DISCUSSION

Cylindroma is a slowly growing malignant tumor that invariably leads to the death of the patient. Most texts credit Billroth with the original description of the tumor, and it was he who coined the term "cylindroma."[3] However, it was Robin and Laboulbéne, in 1853, who gave the first description under the term "heteradenic tumors." Today the term cylindroma is most generally used, although the term "adenoid cystic carcinoma" which is attributed to Ewing is preferred.

Synonyms and related terms of the cylindroma are adenoma, adenomyepithelioma, basal cell carcinoma, basiloma, bronchial adenoma, carcinoid, cylindromatous basal cell carcinoma, cylindromatous basiloma, cystic basal cell carcinoma, mixed tumor, oncocytoma, pleomorphic adenoma with cribriform pattern, primary colloid adenocarcinoma, and adenoid cystic carcinoma.[4]

Cylindroma is one of the most characteristic tumors of the upper respiratory tract.

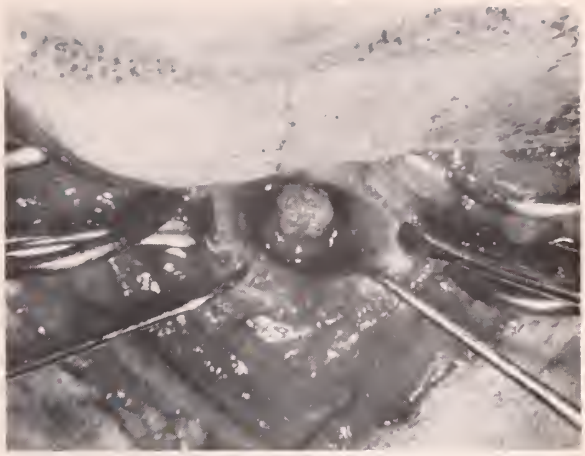

Fig. 2—Appearance of tumor within trachea at time of surgery.

It occurs in the major salivary glands, in the comparable mucous and serous glands of the upper respiratory and digestive tracts, and rarely in other glandular tissue of the head and neck. The cylindroma occurs more frequently than mixed tumors in every location except in the pharynx, and it is predominantly a neoplasm of the nasal cavity and nasal pharynx. It is uncommon in the oral pharynx which is a favorite site for the

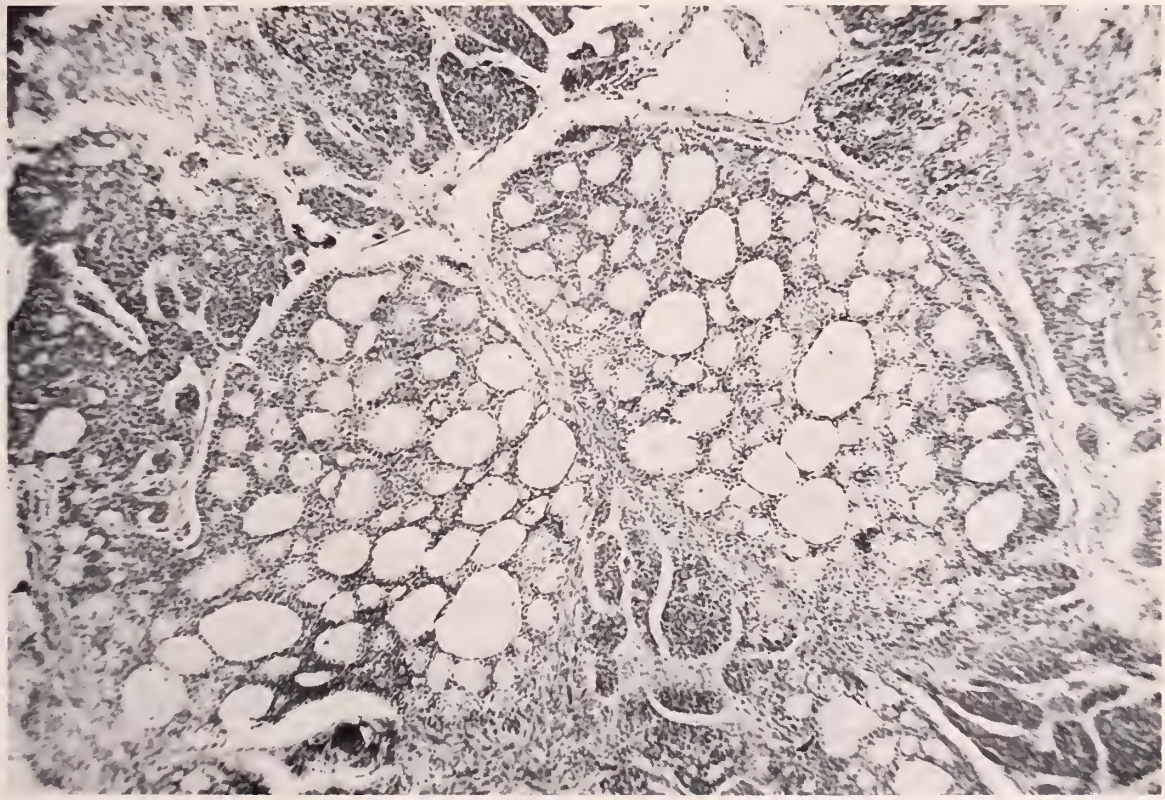

Fig. 3—Histopathologic section of the tumor shows the typical "swiss cheese" appearance of the cylindroma.

usual mixed tumor. It is the feeling of most authors that the tracheal cylindroma arises from the mucous glands.[2,5]

The diagnosis of cylindroma is made on the basis of a characteristic histological appearance. Rounded groups of uniform, small, dark-staining cells enclose multiple spherical or tubular lumens containing hyaline or mucoid material. This produces distinctive cribriform or sieve-like pattern. Cylindromas are often described as having a "swiss cheese" appearance. Perineural invasion is often a prominent feature.

Primary tumors in the larynx and major bronchi are common, but the trachea itself is rarely the site of such a primary tumor. Cylindromas of the trachea are the second most frequent primary tumor of the trachea. Although tumors can develop anywhere in the trachea, they are usually found in the posterior or lateral wall of its lower third. The anterior wall is rarely involved. Most patients are male and are between 40 and 70 years of age.[2]

The first and most prominent symptom in patients with tracheal tumors is dyspnea, and this was present in 90% of cases studied at the Mayo Clinic.[5] Other symptoms were cough, wheezing or stridor, hemoptysis, asthmatic breathing and hoarseness, in decreasing frequency. The majority of the symptoms are on a mechanical basis and arise late in the course of the disease, since approximately 75% of the lumen of the trachea must be occluded before stridor or dyspnea is prominent. An intratracheal tumor with a wide base usually causes obstruction to inspiration and expiration, and stridor would be the most prominent symptom. On the other hand, tumors which have a pedicle and are located in the distal trachea may cause either atelectasis or emphysema, depending on whether there is obstruction to either inspiration or expiration. The majority of patients with tracheal tumors are treated for bronchial asthma with, as might be expected, little effect. There is a maxim that "all that wheezes is not asthma," and this seems especially applicable to tracheal tumors. Consequently, in patients over the age of 40 who suddenly develop symptoms of bronchial asthma which do not respond to the usual treatments for asthma, it might be well to evaluate the patient for a tracheal tumor.

In the past, diagnosis has been mainly on the basis of bronchoscopy, with the chest x-ray film offering little help. Planograms of the trachea are of help in making the diagnosis, as illustrated in the case presented.

The treatment is primarily surgical with plastic repair of the trachea by an autogenous graft or a foreign material which will prevent collapse of the tracheal wall. In a report of 15 cases by Clark, et al[5] at the Mayo Clinic, two general methods of treatment were applied: (1) surgical resection or excision, and (2) endoscopic diathermy or tracheotomy with x-ray therapy or radium therapy, or both. Of the 15 patients who had cylindromas of the trachea, 10 are dead, with the majority of the deaths being in those patients whose tumors were treated with endoscopic surgical diathermy and x-ray therapy. Those patients still in good health had their tracheal cylindromas removed surgically.

Tumors located at or close to the carina pose special problems in adequate ventilation during the resection. Adkins and Izawa[6] have used cardiopulmonary bypass in such cases, and had excellent results.

The clinical course in cylindroma is often protracted, usually following a pattern of relentless infiltration with an ultimate potential for regional and distant metastatic spread. The paramount feature in considering curability is the infiltrating nature of the tumor. The spreading neoplasm invades all tissues in proximity to the primary tumor, and the progress of the tumor is not influenced by anatomic planes. Local recurrence is a common clinical feature of the cylindroma. Smith, et al[7] found that almost all of their local recurrences occurred within eight years.

SUMMARY

A case of cylindroma of the trachea is presented with the pathology, symptomology, treatment, and prognosis of such tumors discussed.

ADDENDUM

A small recurrence was removed through the laryngoscope in July 1967. More radical surgery has been advised.

ACKNOWLEDGMENT: The criticisms and help of Dr. Maxine Bennett (Professor and Chairman, Department of Otolaryngology, University of Wisconsin Medical Center) during the preparation of this manuscript, are greatly appreciated.

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The Spectrum of Patient Care Viewed by a Nurse

By ELEANOR C. LAMBERTSEN, Ed.D., R.N., New York, New York

THE RECENTLY PUBLISHED report of the National Commission on Community Health Services defines the scope and purpose of essential comprehensive personal health services of high quality for all people in each community:

> These services should embrace those directed toward promotion of positive good health, appreciation of established preventive measures, early detection of disease, prompt and effective treatment, and physical, social and vocational rehabilitation of those with residual disabilities. This broad range of personal health services must be patterned so as to assure full and intelligent use by all groups in the community.[1]

Nurses participate as members of the health team in all phases of a comprehensive health program. For the ultimate goal of the nurse as well as of the physician and other members of the health team is to maintain and/or achieve that degree of health attainable for and by an individual or particular social group. But the very nature of a comprehensive health program implies a relative mix of health services and a mix of health service personnel. It is the nature of the results expected that dictates the types of services and types of personnel required—personnel responsible for assuming primary, secondary or supporting roles.

Perhaps progress would be achieved through effective health teams if all of the health disciplines appraised their potential contribution on the basis of primary, secondary and supportive services rather than struggling to define independent functions for themselves and dependent functions for others.

The distinctive nature of the therapeutic relationships of physicians and nurses throughout the historical development of medicine and nursing has tended to complicate any logical analysis of nursing as a separate or distinctive discipline. I hypothesize that the interdependence of medicine and nursing is such that the areas of similarity of function of physicians and nurses will be greater than will be the areas peculiar or distinctive to either. The trend has been evident in the past and will become increasingly evident in the future.

Current and projected advances in medical science and technology require increasing numbers of highly skilled specialists. The traditional health team of the doctor and nurse can no longer serve the health needs of the public. Furthermore, the concept of medical services extends beyond the ill or disabled. But even if one examines "care" of the ill or disabled, the number of skilled personnel required is an indication of the highly specialized nature of these services.

> Once it took only one doctor to resign himself and the child's parents to the inevitable death of a "blue baby." It now takes a team of medical specialists and auxiliary personnel to correct the congenital abnormality of a baby's heart to insure the child a normal life span. At least 15 persons, including four surgeons, are needed in the operating room for repair of a congenital lesion of the heart. More than 100 medical specialists, nurses, and skilled technicians are involved in preparation for, and performance of, the operation and in the post-surgical care of the patient.[2]

Note in this example, the concept of a spectrum of patient care: preparation for surgery, surgery, post-surgical care. In this example, the primary therapy role of the surgeon during surgery is clearly evident; numerous others, such as the anesthesiologist, assume secondary roles or roles vital to sustaining the life of the patient or roles vital to the therapeutic regimen. The role of the nurse, during surgery, is supportive to the primary and secondary roles of those directly concerned with therapy. The competencies required of the nurse are those of predicting the needs of the surgeons and anesthesiologist through the observation of the covert signs and symptomatic response of the patient to surgery. This example is not intended to negate the significance of this area of responsibility in the total regimen of a service, but rather to illustrate the

continued on page 582

Presented during the Wisconsin Work Week of Health, State Medical Society of Wisconsin, Madison, Oct. 16–20, 1967.

Doctor Lambertsen is Director, Division of Nursing Education, Columbia University Teachers College.

[1] National Commission on Community Health Services, *Health is a Community Affair* (Cambridge, Mass.: Harvard University Press, 1966), p. 17.

[2] Lowell T. Coggeshall, M.D., *Planning for Medical Progress Through Education* (Evanston, Ill.: Association of Medical Colleges, 1965), p. 26.

The Vertical Versus the Transverse Abdominal Incision

Comparison by Arterial Gas Analysis

By KLAUS BACKWINKEL, M.D., LUTHER E. HOLMGREN, M.D.
and CARL SCHMIDT, M.D., Madison, Wisconsin

■ THE GREAT VARIATION of incisional approaches in surgery of the abdomen reflects a wide divergence of opinions as to expediency or adequacy of exposure and the physiological qualifications of the different incisions employed. While expediency may have been the prime consideration for surgeons decades ago, the modern techniques of anesthesia have shifted the emphasis to a surgical approach which offers a minimum of physiological disturbances. Merits and demerits of the various abdominal incisions are therefore determined more by their healing tendency and lesser incidence of disrupture, their cosmetic appearance, and lesser interference with pulmonary performance after surgery than by their technical ease. Proper exposure, nevertheless, is imperative for clean anatomical dissection, and for ideal surgery adequate exposure must be balanced with physiological superiority.

The following study attempts to evaluate the effect of vertical incisions versus horizontal incisions on pulmonary ventilation following upper abdominal surgery.

GENERAL CONSIDERATIONS

It is generally agreed that a vertical paramedian incision which retracts the rectus muscle laterally is most expedient and offers optimal exposure. Preference for a horizontal subcostal (Kocher) incision is usually based on the following alleged physiological advantages:[1, 2]

(1) The transverse incision parallels Langer's lines and reduces scarring to a minimum.

(2) The transverse incision avoids a lateral pull on the cut edges of the rectus sheath. Wound closure does not require retention sutures, and the incidence of dehiscence is less. It has been said that a "transverse wound falls together."

(3) Postoperative pain is believed to be less with a transverse incision. This has been judged rather arbitrarily by postoperative narcotic requirements.

(4) Adhesions are thought to be less frequent following transverse incisions.

(5) Last but not least, transverse incisions have been credited with a lower incidence of pulmonary complications. Rees and Coller[1] in comparing 225 transverse with 346 vertical incisions found 2.6% of pulmonary complications in the former and 9.5% in the latter type. Moreover, there were 5 cases of massive atelectasis in the vertical group and none in the group with transverse incisions. This remarkable statistical difference has an appealing interpretation. The vertical incision is incriminated with a high degree of curtailment to the vital capacity because of injury to the lower thoracic nerves. This causes hyperirritability of the sectioned nerves followed by defensive splinting of abdominal muscles, which, in turn, impairs diaphragmatic excursion.

It is our contention that clinical data, such as statistical incidence of atelectasis, pulmonary emboli, postoperative pneumonitis, and assessment of narcotic requirements are arbitrary factors, not well suited for an objective evaluation of a vertical versus a transverse incision.

Furthermore, a determination of vital capacity and changes in maximal inspiratory and expiratory flow rates depends largely on the intelligent cooperation of a patient whose maximum effort after a painful abdominal operation can hardly be expected. We therefore chose measurements of arterial pH, pCO_2, and pO_2 as our method of assaying the effectiveness and adequacy of alveolar ventilation.

From the Department of Surgery, Jackson Clinic (K.B. and L.E.H.), and the Department of Anesthesiology, Methodist Hospital (C.S.).

Investigation supported by a research grant from the Dane County Medical Society Foundation for Medical Research.

Reprint requests to: Klaus Backwinkel, M.D., Jackson Clinic, 30 South Henry Street, Madison, Wis. 53703.

METHODS

(1) Technique: Arterial blood samples were obtained pre- and postoperatively from the left femoral artery, from which they were drawn anaerobically into heparin-coated ampules. The specimens were then placed into a container with crushed ice in order to keep oxidative processes in the blood at a minimum. Determinations were done electronically, using the pH Gas Analyzer, Model 113-S2, of Instrumentation Laboratory, Inc. The preoperative specimens were obtained the day before surgery, while the postoperative specimens were taken 24 hours postoperatively. The difference between the pre- and postoperative values of oxygen saturation was used as an index of diminished pulmonary ventilation.

(2) Cholecystectomies made up 90% of the 39 cases studied, and the remainder consisted of gastric surgery or upper abdominal explorations. Twenty-four patients had a vertical and 17 had a transverse or subcostal incision. All operative procedures were carried out by the same surgical team. Closure techniques were standardized using chromic O sutures for peritoneum and fascia and reinforced by three retention sutures of Mersilene no. 2. Average length of incision was 17 cm for both groups. No abdominal binders were used in the postoperative period. Broncholytic agents or cold steam inhalation were ordered whenever indicated. Cardiopulmonary function in 4 patients with pulmonary disease was greatly improved after they received intermittent positive pressure breathing with a Bird respirator before and after surgery.

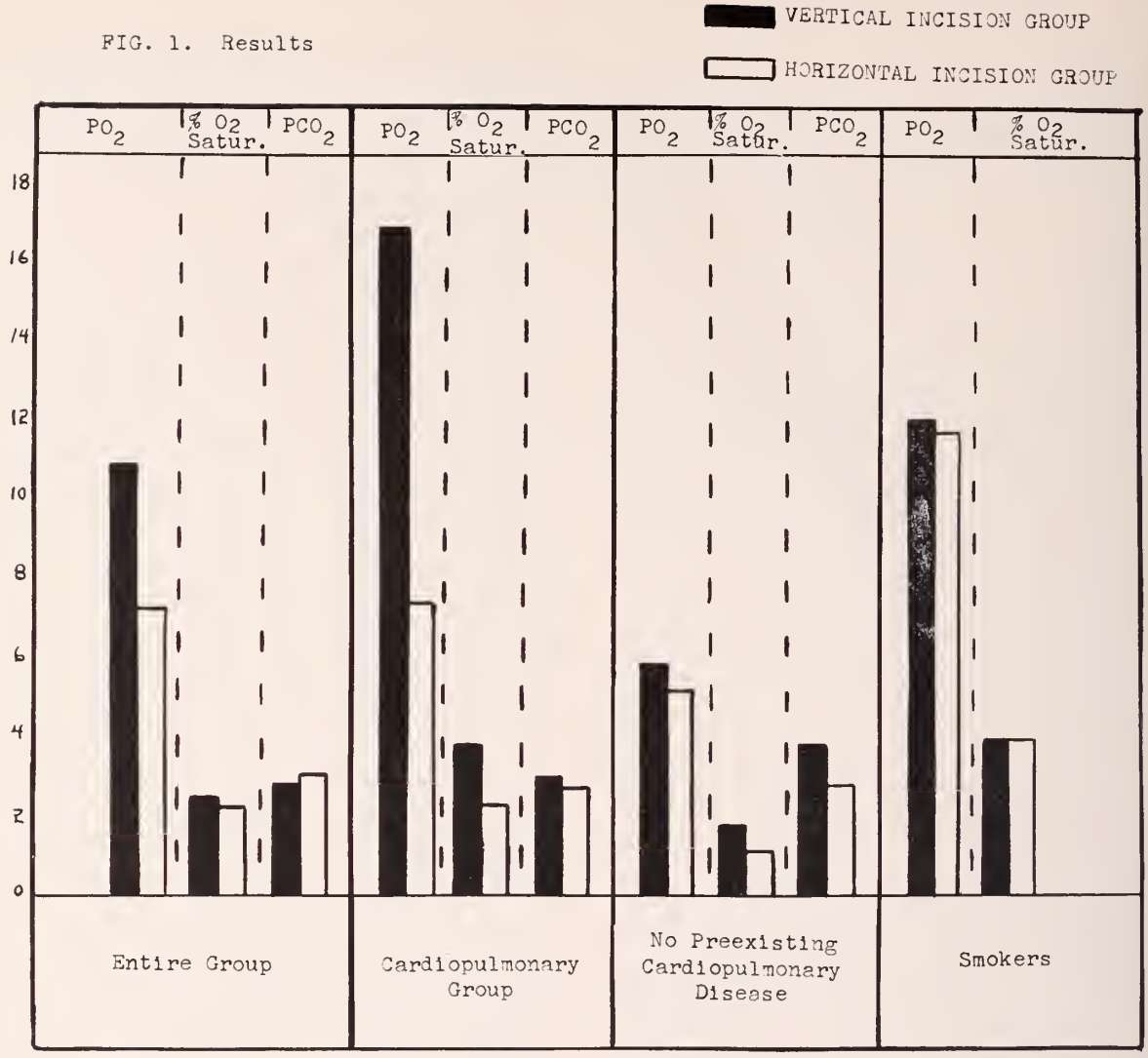
Premedication anesthetic agents and techniques were kept as constant as possible. Premedication consisted of 75 to 100 mg of meperidine hydrochloride (Demerol) and 0.4 mg of atropine given 45 to 75 minutes prior to arrival in the operating suite. One per cent sodium methohexital (Brevital), 100 to 150 mg, intravenously, was used for induction followed by 40 to 60 mg of succinylcholine (Anectine) to facilitate intubation. A no. 16 nasogastric tube was inserted just prior to tracheal intubation. Anesthesia was maintained with nitrous oxide, 3 liters per minute, and oxygen, 1 liter per minute, supplemented with 0.5% to 1% halothane administered via a circle hiflow system. Gallamine triethiodide (Flaxedil), 60 to 200 mg, was given as needed for relaxation. Respiration was controlled throughout the procedure by means of an Ohio Anesthesia Ventilator; the minute volume was calculated from the Radford normogram.

DISCUSSION OF RESULTS

Figure 1 reveals that there was a definite fall in arterial oxygen saturation following abdominal surgery irrespective of the type of incision employed. This finding parallels the studies of Anscombe,[3] who found a reduction of 2 to 3 liters in maximal inspiratory and expiratory flow rates 24 hours postoperatively. A crude comparison of the mean preoperative–postoperative difference of oxygen saturation and partial oxygen pressure between the transverse and vertical groups, however, failed to point out a deviation of statistical significance. In comparing only those patients with preexisting pulmonary disease it seems that the transverse incision affected pulmonary performance less than the vertical one. The fallacy of this deduction becomes immediately apparent by a simple comparison of both groups if only patients known to be free of pulmonary disease were included in the comparison. Here the transverse group shows a mean 1.89% difference of oxygen saturation compared to a 1.31% in the vertical group. (These offsetting results can be explained on the basis of statistically incomparable severity or extent of preexisting pulmonary disease in the two groups.) Supporting this thesis is the incidental finding of considerable postsurgical ventilatory embarrassment in patients who habitually smoked more than 20 cigarettes a day as indicated by a mean 3.4% reduction in arterial oxygen saturation. From the foregoing it may be stated that preexisting cardiopulmonary inadequacy contributed to a significant curtailment of overall pulmonary performance following abdominal surgery, while the type of incision was not a determining factor at all.

On theoretical grounds, we would also like to argue against the widespread belief that the horizontal incision causes less cutaneous irritation or muscle spasm than a vertical one. After all, there is an overlap in the cutaneous branches of the nerves to the anterior abdominal wall, and as Anscombe[3] has already pointed out, the inflammation caused by an incision is not linear but spreads in centrifugal fashion leaving a wide zone of nervous irritation.

FIG. 1. Results



It is well known that increased weight compresses the chest cavity and elevates the diaphragm when the patient is supine and pulls it down when he is erect. The resultant hypoventilation was clearly observed in the obese patients in this study regardless of the type of incision used. Patients with a weight/height ratio of less than 2.6 had a mean oxygen saturation difference of 0.8% as compared to a 2.3% for those with a weight/height ratio between 2.5 and 3.5.

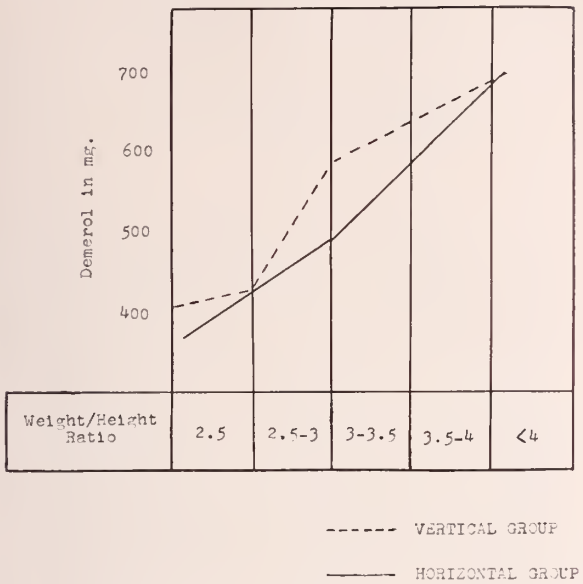
Narcotic requirements (Fig 2) in the postoperative period were directly related to the weight/height ratio. Demerol in 75 to 100 mg doses spaced at four-hour intervals was used exclusively during the first three to four days after surgery. The total dosage was almost identical in both categories with the exception of the slightly obese patient (weight/height ratio of 2.5–3) in the vertical group, who exceeded the total requirements by 100 mg of Demerol. A smoother convalescence of the transverse group can hardly be claimed from such minor differences.

No wound dehiscence occurred in the series. The possibility of an incisional hernia developing in the future, however, should be kept in mind, and conclusions as to the tensile strength of the two incisions may be drawn a year from now. The superiority of a transverse upper abdominal incision in pediatric surgery over a vertical pararectus or muscle-splitting incision with respect to wound disruption is not being questioned.

SUMMARY

The effect of vertical abdominal incisions versus horizontal (subcostal) incisions on pulmonary function following upper abdominal surgery has been investigated. Comparison of the two groups was made by gas

FIG. 2. Total narcotic requirements for first three postoperative days.



analysis determination of the arterial oxygen saturation and partial oxygen pressure before and after surgery. While a mean reduction of 2.3% to 2.4% in oxygen saturation was found in either category, differences of statistical significance were only recorded in patient groups with preexisting pulmonary disease, a history of smoking, or obesity. Narcotic requirements in the postoperative period were grossly identical. Assessment of pulmonary function after abdominal surgery by arterial oxygen gas analysis thus did not confirm a physiological advantage of the transverse-subcostal incision over the vertical one.

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MYCOPLASMA PNEUMONIAE INFECTIONS IN UNIVERSITY OF WISCONSIN STUDENTS

EVANS, A. S., ALLEN, V., and SUELTMANN, S. (State Laboratory of Hygiene Madison Wis.): *Amer. Rev. Resp. Dis.* 96:237–244 (Aug) 1967

The role of *M pneumoniae* in acute respiratory disease syndromes was evaluated in 378 students admitted to the infirmary in the years 1960–1965. Isolation of *M pneumoniae* or rises in complement fixation titer to this agent, or both, were found in 52% of 120 patients with pneumonitis or pneumonia, 5% of 41 patients with acute bronchitis, 4.3% of 92 patients with acute pharyngotonsillitis, and only 0.8% of 125 patients with acute upper respiratory tract infections.

JEJUNOSTOMY IN THE HIGH RISK GASTRECTOMY PATIENT

ROGERS, J. C. T. (Carle Memorial Hospital, Urbana, Ill.): *Surg. Gynec. Obstet.* 125:333–336 (Aug) 1967

The advantages of high jejunal tube enterostomy for gastric decompression in the partially gastrectomized patient were demonstrated in 36 patients in the increased-risk category. The jejunostomy circumvents the nasopharyngeal, esophageal, and epiglottic trauma and the complications attendant to the inlying nasogastric tube. The psychic trauma factor is absent, so sedation need is minimized. Throat irritation and dysphagia are not problems. Ambulation is easy. The jejunostomy tube may remain in place as long as necessary without complications. The tube in the efferent jejunal limb of the gastroenterostomy may prevent kinking and dysfunction. The jejunostomy tube being in the dependent portion of the stomach makes simple gravity drainage effective. There have been no immediate or late untoward sequelae other than two superficial skin infections. There were no deaths.

REPRINTS: HEMOPHILIA THERAPY

Reprints of the proceedings of a Combined Clinical Staff Conference at the National Institutes of Health, published in the *Annals of Internal Medicine*, are now available to interested physicians on request.

THE PHYSIOLOGIC BASIS FOR THERAPY OF CLASSIC HEMOPHILIA (FACTOR VIII DEFICIENCY) AND RELATED DISORDERS

(Vol. 67—No. 4, October 1967)

For additional information write to: Miss Elsie Fahrenthold, Information Officer, Clinical Center, National Institutes of Health, Bethesda, Md. 20014.

* * *

EXTENSION OF MEDICARE "General Enrollment" . . . On September 30, President Johnson signed HR-12026 into law. This extends the "general enrollment" period for purchasing *medical* insurance benefits under the Medicare program through March 31, 1968. Under the previous law, the enrollment period was scheduled to run October, November and December, 1967. The current $3.00 monthly premium for purchasing this coverage will also remain in effect through March 31, 1968.

CLINICOPATHOLOGIC CONFERENCE

P
C

Sponsored by the Section on Pathology, State Medical Society of Wisconsin

Guest Editor: THOMAS T. TANG, Ph.D., M.D.
Milwaukee, Wisconsin

CASE PRESENTATION *

This clinicopathologic conference involves two of four children in a family of Mexican descent who lived in Texas for several generations and recently moved to Milwaukee. The children were two boys, aged 5 and 3 years, and two girls, aged 4 years and 21 months.

Case 1.—The 5-year-old boy, who had epigastric pain of two days' duration, was admitted to the hospital because of aggravation of pain and development of dyspnea. He had been in good health until the last few weeks when he had two episodes of heavy epistaxis. He passed loose brown stools one day prior to admission and vomited once on his way to the hospital. There was no history of allergy or blood dyscrasia in the family.

The child was markedly pale and complained of pain in the abdomen; breathing was rapid and shallow. His temperature was 98.0 F rectally; respirations, 50 per minute and labored; pulse rate, 130 per minute; blood pressure, 160/130 mm Hg; body weight, 39 lb. The abdomen was soft, distended, nontender, with hypoactive bowel sounds; muscle guarding in the right upper quadrant; and no markedly enlarged organs.

Laboratory findings were as follows: hemoglobin, 7.1 gm/100 ml; hematocrit, 25%; and white blood cell count, 22,000/cu mm, with a differential of 64 segmented neutrophils, 28 lymphocytes, 3 monocytes, 4 eosinophils, and 1 basophil. Blood chemistry studies revealed: sodium, 134; potassium, 5.9; carbon dioxide, 17.3; chloride, 97 mEq/L; pH, 7.23; blood urea nitrogen, 13 mg/100 ml. Serum iron was 28 mcg/100 ml; serum iron-binding capacity, 341 mcg/100 ml. Urinalysis studies showed: protein, 3+; sugar, 2+; acetone, negative; occult blood, strongly positive; red blood cells, 10 to 15 per high-power field; white blood cells, packed; many granules and hyaline casts. Bacteriological culture revealed the nasopharynx positive for coagulase-positive staphylococcus and beta-hemolytic streptococcus; urine, negative for bacteria.

The patient was placed in a croupette with oxygen and given 0.5 N saline/2.5gm% dextrose intravenously. Two hours after the first physical examination, diffuse crepitation and râles were heard in both lungs. Packed red blood cells were given with fluid intravenously. The patient remained restless, asked for water, and complained of suffocation. His blood pressure was 150/120 mm Hg. Hydralazine hydrochloride (Apresoline) and reserpine were given intramuscularly. Penicillin also was administered. One hour later his blood pressure was 140/90. The patient appeared to be more at ease although his breathing remained labored and his lungs were congested. A chest x-ray film demonstrated extensive pulmonary edema. Digoxin was given. His rectal temperature rose to 102.0 F and he was placed in a Thermorite. He voided 90 ml of dark, smoky urine. His condition continued to deteriorate and he died 18 hours after admission.

Case 2.—The 3-year-old boy was admitted to the hospital the day after the death of his brother because of a sudden onset of epigastric pain and dyspnea. He had been in good health and had no history of hematuria, edema, vomiting, diarrhea, or allergy. Because of the concomitant onset of illness and similarity of symptoms of these two brothers, poisoning was highly suspected. Through questioning of the parents, it was learned that the children had eaten the berries of Solanum dulcamara (European bittersweet) and had played in an area sprayed with rat poison. For this reason, the two sisters also were hospitalized for observation, although both were free of any symptoms.

Examination of the boy revealed a pale and irritable child, complaining of abdominal pain and unable to urinate. His temperature was 99.0 F rectally; respirations, 64 per minute; pulse rate, 170 per minute; blood pressure, 130/95 mm Hg; body weight, 31¾ lb. His pupils were constricted and reacted to light. Slight edema was noted in the face and eyelids. A few rhonchi were present in both lungs. Electrocardiographic studies showed flat T waves in lead 1 and slightly inverted T waves in leads VL and V_2 through V_5. There was no indication of electrolyte disorder. The abdomen was soft and not distended. The liver margin was 5 cm below the right costal margin. Chest x-ray films demonstrated pleural effusion, pulmonary edema, and bronchopneumonia. The abdominal x-ray films were essentially normal.

Laboratory studies revealed the following values: hemoglobin, 8.5 gm/100 ml; hematocrit, 29%; and white blood cells, 22,400/cu mm, with a differential count of 87 segmented neutrophils and 13

* From Milwaukee Children's Hospital.

lymphocytes. The red blood cell study was negative for Heinz bodies. Blood chemistry studies showed sodium content of 134; potassium, 4.8; carbon dioxide, 8.3; and chloride, 105 mEq/L; pH, 7.37; BUN, 39 mg/100 ml; total bilirubin, 0.4 mg/100 ml; serum hemoglobin, 4 mg/100 ml; SGOT, 21 units/ml; salicylate, 3 mg/100 ml; glucose-6-phosphate dehydrogenase, 135 units/100 ml of RBC (normal); lead, 12 mcg/100 ml. Urinalysis showed protein, 4+; sugar, none; acetone, moderate; occult blood, strongly positive; RBC, packed; many hyaline casts; urine solanine, negative. Antistreptolysin titer, 625 Todd units. Bacterial cultures of throat and nasopharynx showed a few pneumococci; urine and stools, negative. Fecal examinations demonstrated Entamoeba histolytica and Giardia lamblia.

The boy was digitalized, placed in an oxygen tent, and given penicillin, hydralazine, reserpine, and 5% dextrose in water in a minimal amount to replace invisible loss of water. He was irritable and remained oliguric the first day. The child was under constant intensive care. He developed diuresis the next day. The urine was dark and smoky. He gradually recovered and was discharged after one month's hospitalization.

RADIOLOGIC FINDINGS

Dr. Donald P. Babbitt (Radiologist): In the portable x-ray chest film of the patient in Case 1, one can readily identify the cardiomegaly and haziness which is generalized over both lung fields but slightly more marked on the right side, representing pulmonary edema, with evidence of minimal pleural fluid in the right costophrenic sulcus. This appearance is relatively nonspecific and indicative of cardiomegaly and pulmonary edema. After the child's demise, an anteroposterior x-ray film of the knees was taken in an effort to determine any evidences of plumbism, but there was no abnormality.

The patient in Case 2 demonstrated much the same features radiologically but to a less marked degree. A density in the chest was demonstrated to represent fluid rather than pleural reaction, proven by the fact that when the child was upright or supine, this density changed its position. In addition to the presence of fluid, there was some haziness and poor delineation of the vascular structures consistent with congestive changes. I could not be certain whether there was concurrent pneumonia. Two days later improvement was noted with decrease of fluid and some clearing of the lung fields. By the sixth day after the initial film, the lungs had cleared and the only persistent finding was cardiomegaly. An excretory urogram was within normal limits.

CLINICAL DISCUSSION

Dr. Edward J. Lennon (Director of Clinical Research Center, Milwaukee County General Hospital): These are interesting problems. After reviewing the protocol in Case 1, I note there is no mention of the patient's state of mentation: was he confused or disoriented? When his urine was examined, hematuria was found. The coincidence of hypertension, cardiomegaly by x-ray examination of the chest, abdominal tenderness particularly over the liver area, and hematuria would lead me to a strong presumptive diagnosis of acute glomerulonephritis, even without further information. Moderately severe anemia was found with a hemoglobin level of 7.1 gm/100 ml and a hematocrit of 25%; my hasty calculations indicate a mean corpuscular hemoglobin concentration of 28. While this is not markedly reduced, it is compatible with iron-deficiency anemia and this issue appeared to be settled some time later when the serum iron was found to be 28 mcg/100 ml with a serum iron-binding capacity of 341. No specific comments were made about red cell morphology nor any comment about evidence of an increase in reticulocytes or a decrease of platelets.

We have no evidence to suggest that this child had had a hemolytic episode. It is a bit disconcerting to note that his plasma urea nitrogen concentration was normal at 13 mg/100 ml, but this may be the case on occasion early in the course of acute glomerulonephritis. A mild metabolic acidosis was also present. This was very poorly compensated, with much less lowering of carbon dioxide pressure (pCO_2) than I would have expected in acute acidosis. His calculated pCO_2 was about 40 mm of mercury which means almost no respiratory compensation despite the presence of fearful dyspnea and tachypnea. I would have to conclude either that something went awry in the laboratory analyses or that this child had such poor ventilatory exchange that he wasn't really able to efficiently clear CO_2 from his lungs. The absence of cyanosis would certainly suggest that CO_2 should be able to diffuse readily out of his lungs. The other disturbing fact about his blood chemical measurements is that he has an increased concentra-

tion of "unmeasured anions." If one subtracts from the serum sodium concentration the sum of the concentration of total CO_2 content and chloride, one gets an estimate of the total quantity of anions, which are not normally measured in the laboratory. These anions consist principally of negatively charged protein molecules and phosphate, sulfate, and a small amount of organic acid anions. In adults, the unmeasured anions normally range between 6 and 12 mEq/L. In this little boy, the unmeasured anion concentration of the blood calculates out to be 20 mEq/L. This at least raises the question of an organic acidosis. It is conceivable that in the face of anemia, a poor cardiac output, peripheral vasoconstriction, and thus diminished delivery of oxygen to the tissues, that this child, indeed, had an elevated blood lactate concentration. While this is possible, I have no way of proving it.

His urine contained 3+ protein, 2+ sugar, and no acetone. Thus, organic acidosis due to ketoacids appears unlikely. I don't really know how to explain the presence of glucose in his urine, and I will dismiss it. Red cells as well as hyaline and granular casts were identified on microscopic examination of his sediment. I am quite surprised that red blood cell casts were not seen. However, casts are fragile things, and if the urine was very dilute or if it stood for a time before getting to the laboratory, these could have disappeared. Unless a freshly voided urine specimen is examined promptly, it is unlikely that important microscopic elements such as red blood cell casts will be identified. It is important to note that none of the "muddy brown pigmented casts" which are commonly seen in acute renal failure were present, and that no calcium oxalate crystals or crystals of other sort were described. These bits of negative information are important for some of our later considerations. One extraordinarily important finding is that beta-hemolytic streptococci were cultured from the boy's throat.

The child was put in a Croupette and given oxygen. It is then stated that he was given half-normal saline and 2.5% glucose. I wonder if someone could tell me how much of the fluids he received and over what period of time?

I think we must raise the question of whether the intravenous fluids contributed to the worsening of his congestive heart failure. I think he was in heart failure when he was admitted to the hospital, and we know that he was producing very little urine. The combination of intravenous fluids and the administration of packed red cells may well have contributed to the development of overt pulmonary edema, from which I believe he died. A few hours after admission pulmonary edema was obvious; this was confirmed by x-ray studies. His temperature rose to 102.0 F. This may have been due to congestive heart failure alone, but possibilities of other infections are not excluded. He later voided 90 ml of urine which was dark and smoky in color and clearly contained blood.

The following morning the patient's brother was brought into the hospital with similar complaints. A review of the protocol reveals no flank tenderness in this little boy, nor in his older brother. The calculated mean corpuscular hemoglobin concentration was 29. I presume that there was no reticulocytosis or evidence of a decrease in platelets on his peripheral smear since no mention is made of these. He, too, had a low serum total CO_2 content, but his pCO_2 calculated out to be 14 mm of mercury, much more in keeping with the usual expected good respiratory response to an acute metabolic acidosis. His laboratory studies are not particularly worth comment, except to note that he had an increase in unmeasured anions, with a value of 21 mEq/L calculated. Urinalysis showed 4+ protein and a moderate amount of acetone, perhaps related to relative starvation. The urine was packed with red blood cells and hyaline casts and although red blood cell casts were not reported, I would again be surprised if they were not, indeed, present. His antistreptolysin O titer was elevated, indicating contact with the Streptococcus in the not too remote past. He was treated with fluid restriction, antihypertensive drugs, penicillin, digitalis, and oxygen. Oliguria was present for a day and then diuresis began, and over a period of a month the little boy recovered.

I think that these are two instances of acute poststreptococcal glomerulonephritis which are unusual only in that congestive heart failure was extraordinarily severe in each child. It seems possible to me that the presence of moderately severe iron-deficiency anemia in both of the children may have predisposed them to the development of con-

gestive heart failure when challenged by hypertension and fluid accumulation.

Let's turn to the question of poisoning which was raised. Before I can be sold the possibility that these children died of exogenous poisoning, someone would have to propose to me a poison which would explain hypertension and heart failure in addition to their other findings. Both of the children are said to have eaten the berries of the European bittersweet, which contain solanine. However, the youngest boy's urine was examined, and no solanine was found. Furthermore, so far as I could determine in a frantic search of the library, this simply is not the clinical picture of solanine poisoning. I have had no personal experience with solanine poisoning, but I understand that it produces symptoms very much like that of atropine, with pupillary dilatation, abdominal cramps, tachycardia, fever, dysphasia, hallucinations, and death, if it occurs, as a result of respiratory failure. I found nothing in the literature to suggest this toxin could produce renal damage, which both of these children clearly had, nor any evidence that it is associated with hypertension or heart failure.

Secondly, the children were said to have played in an area which had been sprayed with a rodenticide. Again in my perusal of the toxicologic literature, I could find only a single agent used as a rodenticide which might be considered. The agent to which I refer is barium carbonate. This produces marked sensitization of both skeletal and smooth muscles and makes them irritable, so that fasciculations, tremors, spasms, and sometimes convulsions are produced. Barium carbonate is also said to cause constriction of the smooth muscles of blood vessels and is associated with hypertension, but the mechanism of death in patients poisoned with soluble barium is usually ventricular fibrillation. No unusual neuromuscular irritability was described in either child, so I doubt that this has to be considered.

The presence of some increase in unmeassured anions in both children raises the question of an organic acidosis, as we noted before. I suppose one must then consider the ingestion of substances such as ethylene glycol, which is metabolized in the body to form oxalate and which does produce a picture of pulmonary edema and severe metabolic acidosis with associated hyperventilation. However, it is usually associated with marked obtundation, sometimes with seizures, and usually the liver is damaged as well as the kidneys. Renal damage following ethylene glycol ingestion results from the precipitation of oxalate crystals in the kidneys causing acute renal failure, and again the absence of oxalate crystals in the urine is against this diagnosis. Carbon tetrachloride poisoning also could have caused renal damage, but it could not explain the entire clinical picture as described. I am glad that the younger child, in Case 2, did not have an elevated blood salicylate level or an elevated blood lead level, since it would have been necessary for me to ignore these, again, because they simply would not produce this sort of clinical picture. Finally, those chemical agents which yield oxidizing substances in the body can produce an acute intravascular hemolysis in certain susceptible individuals. While I do not think there was really any evidence that intravascular hemolysis had occurred, I gather that this was considered because of some of the studies. For example, the glucose-6-phosphate dehydrogenase (G6PD) level was measured in the younger child and found to be normal. This pretty well excludes hemolysis due to an oxidizing agent which usually occurs only in individuals with genetically determined deficiencies in G6PD. No Heinz bodies were seen on peripheral smear and this is usually the hallmark of intravascular hemolysis of this kind. Finally, the serum hemoglobin was normal in the second child as was the serum bilirubin. I think, therefore, that there is no evidence that intravascular hemolysis occurred in either child and this is helpful in excluding one other possibility that I have read about but not seen— that is, the so-called hemolytic-uremic syndrome, which is a syndrome of nephritis and cortical necrosis often associated with diarrhea and hemolytic anemia in young children.

In summary, two children in the same family presenting with heart failure without underlying valvular disease immediately raised in my mind the suspicion of acute glomerulonephritis. The coexistence of hypertension, abnormal urinary sediments with hematuria, and the demonstration that both children had had recent streptococcal infections satisfied me that this diagnosis is correct, and the Pathology Department will have to talk long and hard to persuade me that this is incorrect. I think that both chil-

dren also had an iron-deficiency anemia, but I am unable to say whether this was due to faulty nutrition or other causes.

Dr. Thomas A. Good (Associate Professor of Pediatrics, Marquette School of Medicine) : I would agree that I likewise would have to be persuaded quite long and hard to be talked out of that diagnosis. The problem, of course, is that in all of these CPCs pathologists extrapolate death back into life, and they always seem to have some advantage. However, when we are dealing with the living patients, it is a different story from that relating to a CPC. The first little boy (Case 1) died very rapidly. The diagnosis initially was that of acute glomerulonephritis. There did not seem to be anything particular to steer one away from that diagnosis. The treatment was directed at correcting the hemoglobin level and putting a sick child on maintenance fluid, particularly when the little fellow did not show pulmonary edema. This is an extremely hazardous business as far as I am concerned, and the older I get the less I like intravenous fluids in acute renal failure. I think that this was quite evident in the second child (Case 2) where I threatened a number of times to cut the intravenous tubing in order to keep the house staff from putting any fluid into the child.

This second little fellow was in frank, severe heart failure and was in real trouble at the time we saw him. Fortunately, he did not die. He did not respond at all to hydralazine or reserpine, nor did the first child, as far as lowering the blood pressures to protect his heart. The whole situation was rather precarious for a while until he diuresed, and it surprised the house staff considerably to see him diurese three liters of fluid, which is the amount of fluid that is just pumping around in extracellular space. I think that this observation takes care of the problem of treatment; do nothing to increase the load on the child's heart.

Dealing with these children's problems gave us a rough time, because they were Spanish-speaking people. We had a hard time getting an adequate history, and when I became involved in the case the second day, the first child had already died. We obtained a half-dozen stories and finally straightened them out with the aid of our Spanish interpreter who was one of the house staff. At first there seemed to be some belligerance on the part of the parents, because this older boy had been under study for vague abdominal complaints, dating back about six months. This confused the picture as to whether he really did have an acute illness or had manifestations of a chronic illness that suddenly exacerbated. Anyway, the problem of poisoning always comes up. The other two younger siblings had acute complaints of abdominal distress. Naturally when you have four little children, and the oldest boy is the sickest, you start worrying about a poisoning, because of the fact that the oldest child usually is the one who will take the most, unless he knows it is a poison, and then he will feed it to the next oldest. This is a typical pattern. You are not going to have any trouble finding a poison. If you look around you always find it. So we talked about whether there were any berries or anything like that around, and they produced a nice bunch of berries on the table in no time at all. These berries produce a nervous intoxication, and the second little boy, as sick as he was, was still quite sharp. He could not speak English, but he was alert and was not in central nervous system intoxication in spite of severe heart failure. This just was not the alkaloid poisoning picture, and we discounted the idea that he was poisoned with the berries. We did find other interesting factors. The mother recently had used up a bottle of pine oil, and the children had aided her in utilizing this furniture polish. We do not look for intoxication just by the oral route, since kidney intoxication often occurs with inhalants as well. If one inhales carbon tetrachloride, it predominately produces kidney intoxication, while by ingestion it produces liver intoxication. The pine oil's active ingredient is turpentine, and turpentine is a pretty poisonous principal. But we have nothing that would suggest that these children really had turpentine intoxication. The other consideration was that a shed they used for a sandbox had been previously inhabited by rats. The older rodenticides have thallium, which can cause renal damage, but acute glomerular intoxication is rarely seen.

We did not see anything unusual in the bone x-ray films. Thallium is like lead but is a little tougher product with which to deal. These were the major considerations at the time we treated the children. My diagnosis still remains acute glomerulonephritis.

In the studies of the younger siblings, I

think one of them had a bit of pneumonitis on x-ray examination. Now that we have all of the reports in, we can arrive at a diagnosis that the two children had acute streptococcal glomerulonephritis. This is an epidemic disease, and it is not uncommon to see it in several members of a family. It usually does not occur at the same time; however, one generally sees one and then the next and the next, so that I have often put the entire family on prophylactic penicillin in order to eliminate the possibility of further nephritis. You can not do anything after the attack has occurred. We are gratified in the response the second boy made, and I think that our insistence in giving him no more fluid than insensible water loss was correct. In fact, one did not have to give him anything. He had an extra 3,000 ml of his own fluid, which was certainly more physiologic than what we might administer. There was no point in giving him any more.

In cases of acute glomerulonephritis where there is any evidence of edema, it is better to wait and lower their blood pressure with an hydralazine-reserpine cocktail than to attempt to manipulate their fluids. I cannot understand why neither of these children responded to quite adequate doses of hydralazine and reserpine; most children with glomerulonephritis do so. I think these children had acute glomerulonephritis, the older boy dying from acute cardiac failure which is the most common cause of death in this particular disorder. The failure to lower their blood pressures may have been due to the hypervolemia.

PATHOLOGIC DISCUSSION

Dr. Thomas T. Tang: During autopsy studies, we constantly attempted to rule out the possibility of poisoning in this case. The gastric contents, body fluids, and frozen tissues were saved for toxicologic study. The body of the boy was well developed but poorly nourished. The skin was pale and so were the conjunctivae, nailbeds, and oral mucosa. However, no rashes, ecchymoses, or petechiae were observed anywhere to suggest poisoning by atropine, belladonna alkaloid, warfarin, or phosphorus.

The heart weighed 150 gm, about 50% heavier than the average in this age group. There were ventricular dilatation and hypertrophy. The pericardium contained 25 to 30 ml of clear fluid. About 60 ml of similar fluid were found in each pleural cavity, with 150 ml of ascitic fluid in the peritoneal cavity. Some edema was noted in the skin and in both lungs, and passive congestion in the liver and spleen. The child seemed to have died from congestive heart failure, which was attributable to a high cardiac output and hypervolemia and could account for the dyspnea of the patient. In examining the gastrointestinal tract, we did not find any berries, which were allegedly eaten by the child, but instead numerous round worms (Ascaris lumbricoides) inside the distal ileum (Fig 1). This helminthic infestation had undoubtedly affected the nutritional status of the patient.

The liver showed no fatty change or necrosis as one would sometimes see in cases of poisoning. The kidneys were normal in color and size. However, microscopically, the kidneys revealed enlarged glomeruli with increased endothelial and mesangial cellularity (Figs 2 and 3) and some glomeruli were hemorrhagic with blood inside the urinary spaces (Fig 4) and convoluted tubules. This is a classical picture of acute glomerulonephritis. No degeneration or necrosis of renal tubules was seen to suggest nephrotoxic poisoning. Besides, I cannot think of any nephrotoxic substances, such as mercury, bismuth, outdated tetracyclines and sulfonamides, that could produce glomerular lesions like this.

If the older boy had acute glomerulonephritis, could the younger one also have it? With this in mind we obtained a renal biopsy from the surviving brother and found almost identical lesions in the glomeruli. To confirm our diagnosis, we ordered an electromicroscopic examination of the renal biopsy. Doctor Garancis will discuss the electromicroscopic findings of the kidney.

Dr. John C. Garancis (Assistant Professor of Pathology, Marquette School of Medicine): The lumina of the glomerular capillaries were considerably reduced by the presence of numerous neutrophilic granulocytes and swelling of endothelial cells. In some instances, the increased size of endothelial cells was accompanied by decreased cytoplasmic density. The loss of foot-process or organization of epithelial cells was a constant finding. Frequently, cytoplasmic sheets of epithelial cells abutted on the outer surfaces of the basement membrane (Fig 5). The most striking finding was the dense subepithelial

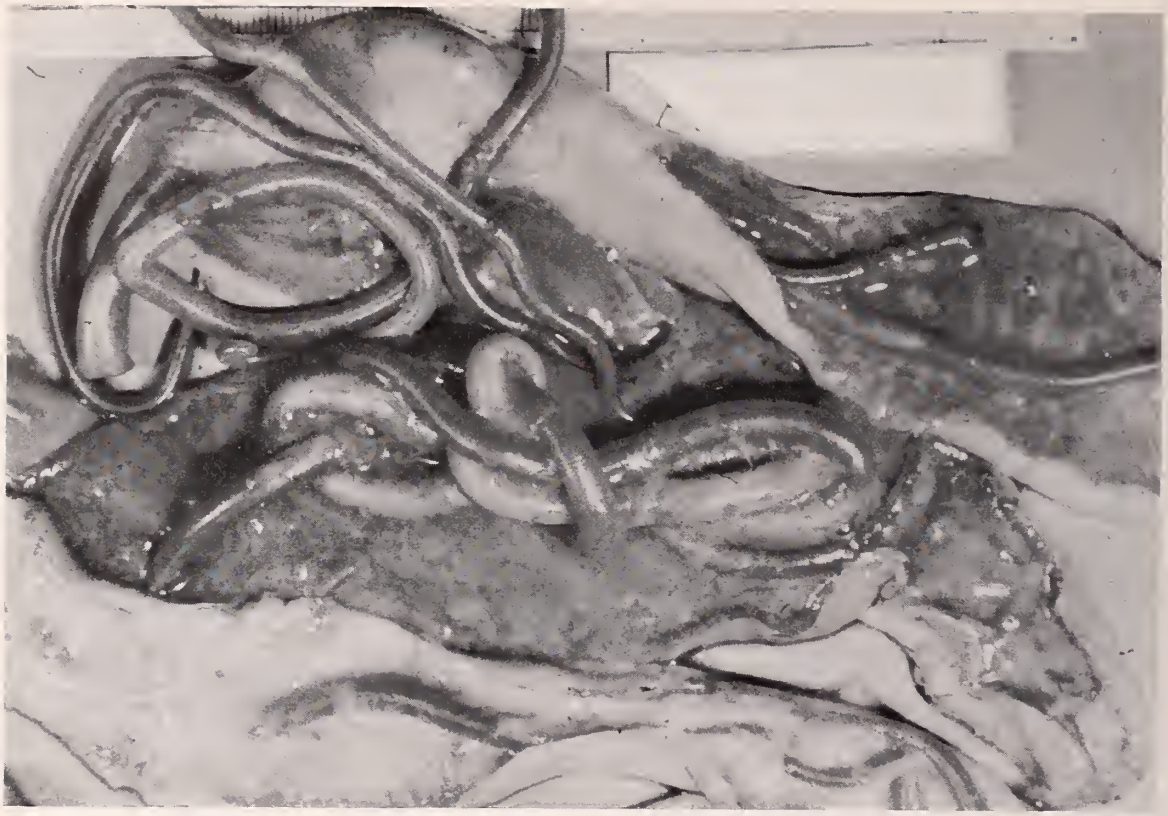

Fig. 1—Adult ascarides in distal ileum.

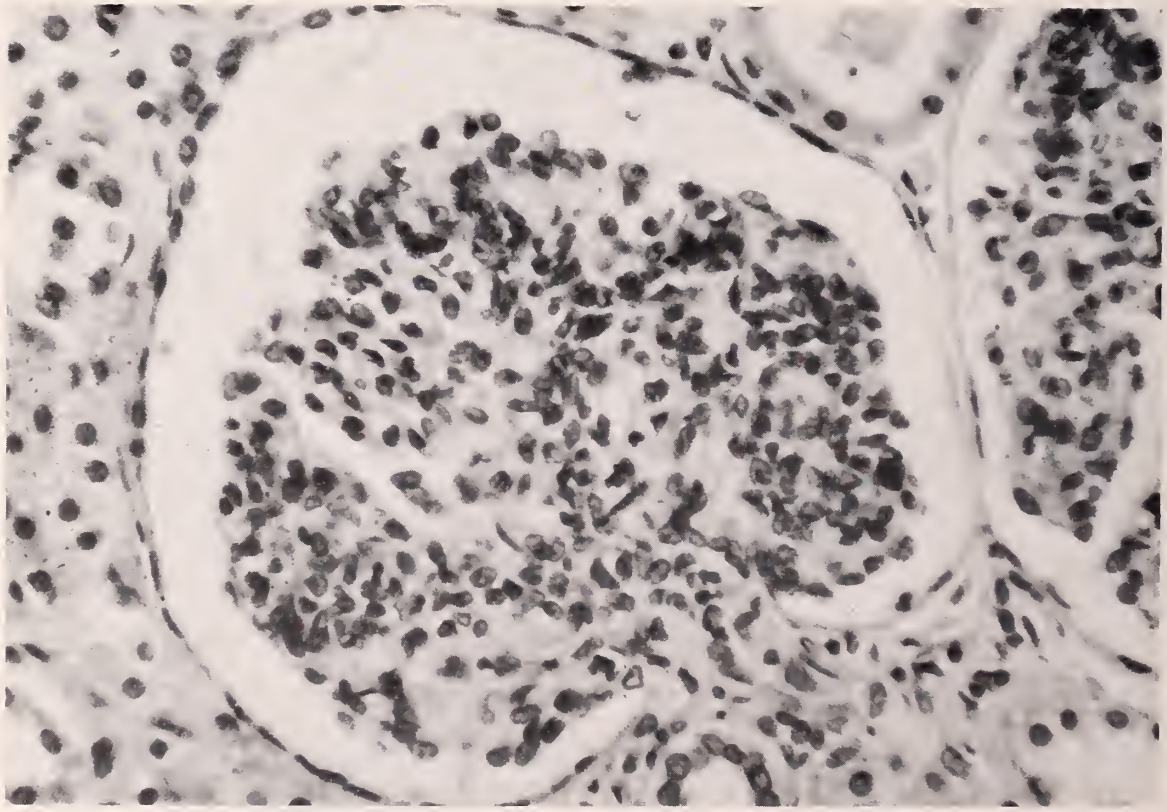

Fig. 2—Hypercellular glomerulus, showing endothelial proliferation.

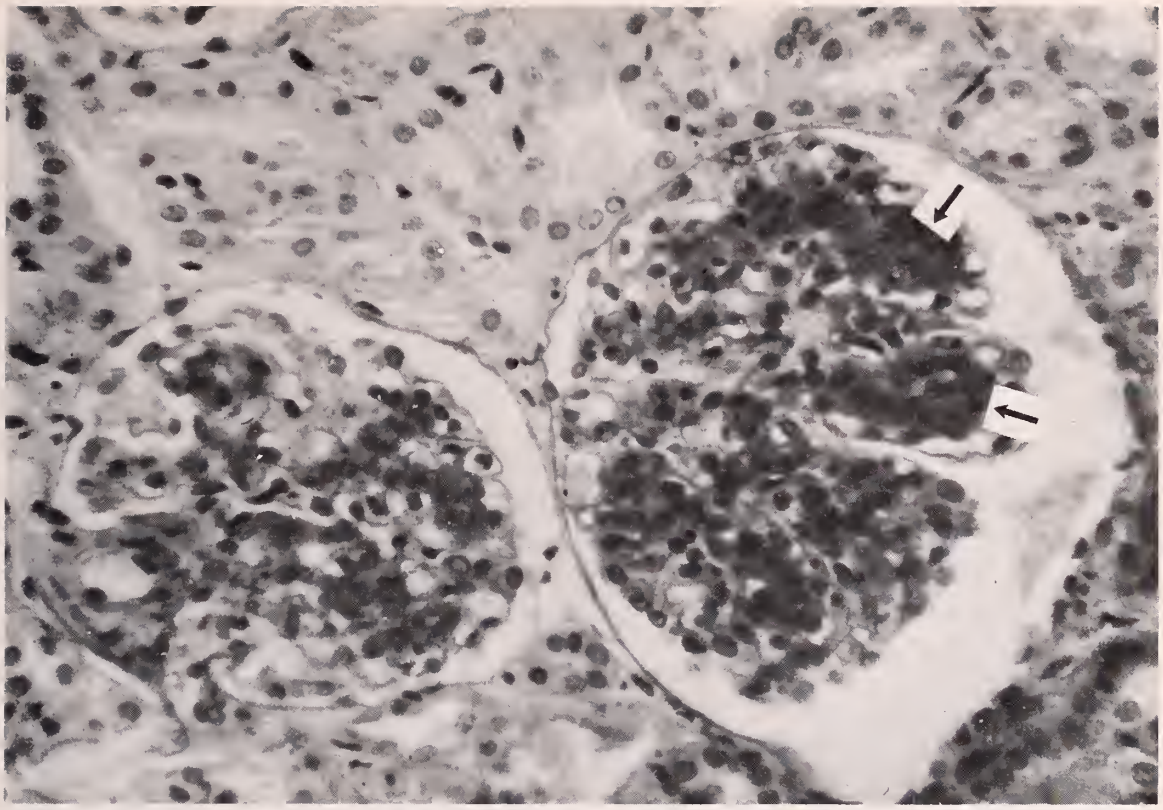

Fig. 3—Acute glomerulonephritis characterized by mesangial proliferation (indicated by arrows).

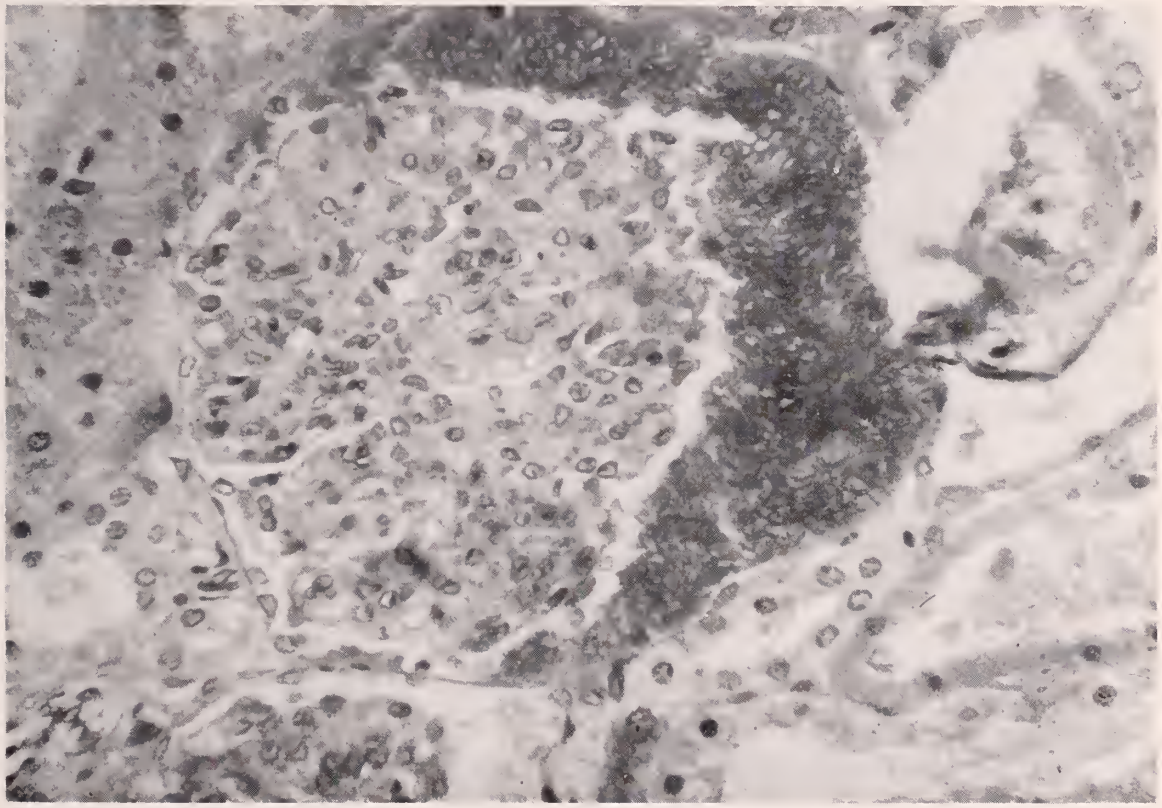

Fig. 4—Hemorrhagic glomerulus.

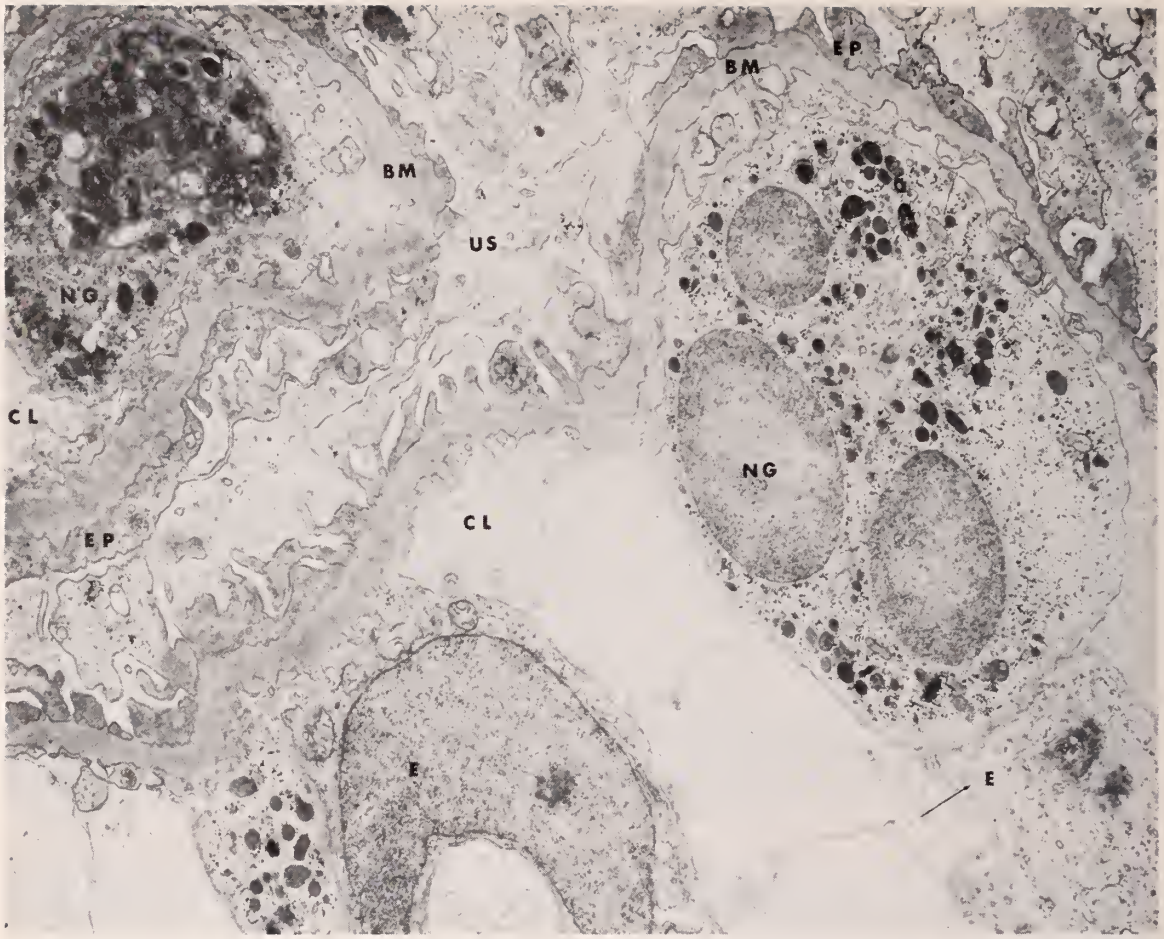

Fig. 5—Two glomerular capillaries. Each contains neutrophilic granulocytes (NG); endothelium (E) is swollen in some areas (arrow); epithelium (EP) shows fusion of foot-processes; basement membrane (BM) is irregular. (CL) capillary lumen; (US) urinary space x 20,000.

deposits, or "humps" as called by some investigators (Fig 6).

The hump is characterized by a deposit of electron-dense material on the epithelial surface of the basement membrane. As Osawa et al[1] described, they are separated from lamina densa by a clearly visible lamina vara. These deposits are usually well circumscribed, sessile, or rounded elevations. They vary in density, frequently being denser than lamina densa proper.

There are five other variants of the hump; however, for practical reasons, only the variant A is described briefly. It is essentially similar to the usual hump, except for the absence of lamina vara externa at the base of this deposit. Jennings does not make a distinction between the hump and the variant A. Since I am using Margalas as embedding material for electron microscopy, lamina vara is not well recognizable. Therefore, I consider the hump and the variant A to be the same and refer to it as "hump."

Humps are frequent and characteristic findings of poststreptococcal glomerulonephritis. The absence of humps is not related directly to the duration of disease, because they are observed in cases with clinical signs of continuous glomerulonephritis of 12 months' duration. They are not found in glomerulonephritis with heavy proteinuria.

COMMENT

Dr. Tang: From these observations, we are quite confident that both children became ill because of acute glomerulonephritis and not poisoning. It is of interest to note that acute glomerulonephritis may strike more than one member in the family, thus simulating an incidence of poisoning. Recently, Yuceoglu, et al[2] have reported that twin brothers had acute glomerulitis about the same time and the authors attribute this

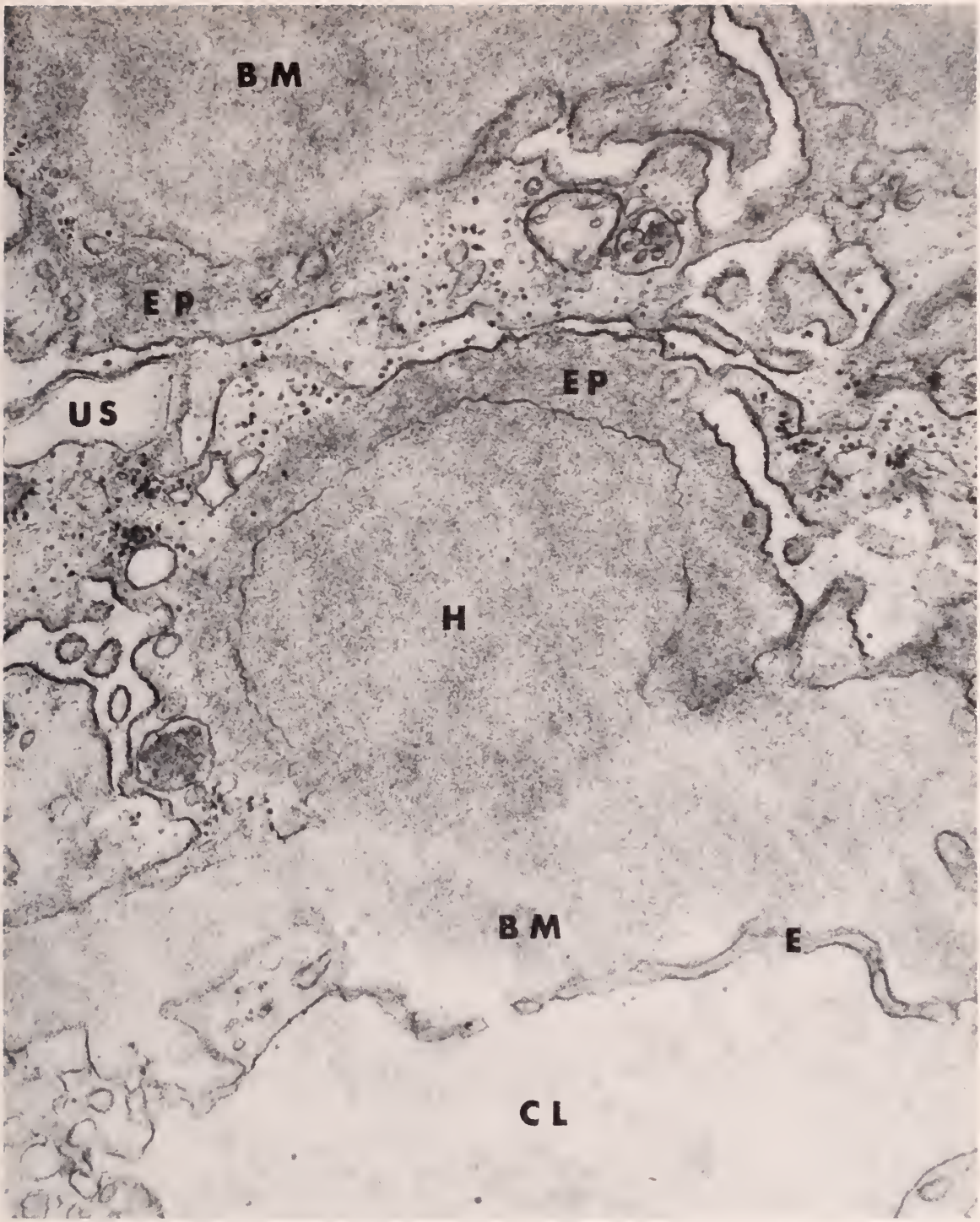

Fig. 6—Subepithelial deposit—hump (H), (CL) capillary lumen, basement membrane (BM), epithelium (EP), endothelium (E), urinary space (US) x 45,000.

coincidence of illness to ECHO virus type 9 infection. They have also pointed out that during the summer of 1957 there was an ECHO 9 epidemic in Milwaukee, and nearly 50% of the infected patients had microscopic hematuria. Whether these two little boys had ECHO virus infection I am not sure, although I believe they had some evidence of streptococcal infection. It is probable that acute glomerulonephritis may be precipitated by either streptococcal or viral infection, and present as an endemic disease.

CLINICAL DIAGNOSIS

1. Acute glomerulonephritis.
2. Pulmonary congestion.

PATHOLOGIC DIAGNOSIS

1. Acute proliferative and hemorrhagic glomerulonephritis.
2. Ascariasis.
3. Anemia.
4. Congestive heart failure.

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WISCONSIN'S HEALTH

by E. H. JORRIS, M.D., State Health Officer

HEALTH UNIT FINDING X-RAY OPERATORS SAFE

In the second round of surveying the safety of dental and medical x-ray machines in Wisconsin, the Division of Health is securing an evaluation of exposure to dentists, physicians, and others who work in offices where x-ray equipment is used.

These persons are furnished a film badge which is worn for a month then sent to the Division of Health for analysis. Test results to date show that x-ray radiation is being controlled successfully and that exposure of staff personnel, and patients, too, is well within established limits.

One of today's most valuable aids in the diagnosis of human diseases, defects, and injuries is the x-ray machine. Since its invention 70 years ago, great advances have been made in both the design of the x-ray machines and the techniques employed in their use. In all of the developmental work to date, the ultimate goals have been to provide the maximum amount of useful diagnostic information with the minimum of radiation exposure of both the patient and the operator.

These are also the goals of the Radiation Protection Section of the Division of Health. All of the x-ray machines in the state are registered annually with this agency. Annual registration provides current up-to-date information on the location and type of use of all of the x-ray equipment used in Wisconsin. Radiation specialists from this agency survey each x-ray machine to be sure that the design and construction of the machine complies with the requirements of the Wisconsin Radiation Protection Code and that the use of the equipment does not result in unnecessary or unproductive x-ray exposure.

Whenever it is found during a survey that the x-ray beam produced by the equipment covers too large an area of the body or is of poor quality, corrections to the equipment are made by the radiation specialists. All of the 2,212 dental x-ray machines used in Wisconsin have been surveyed and now meet all of the radiation safety requirements. Over 80% of the 2,182 medical diagnostic x-ray machines have also been surveyed and corrected.

The surveying of x-ray facilities is a continuing program of the Radiation Protection Section. At the time of the surveys, improvements in the techniques being used are also discussed with the personnel operating the x-ray machines. One improvement always discussed is the use of higher speed films which require a shorter exposure and thereby reduce the exposure of both the patient and the operator.

DEMAND FOR PHYSICAL THERAPISTS SOARS

Physical therapy is a fairly new health profession, having had its beginning just over 50 years ago, but the demand for rehabilitation services from physical therapists has soared in the last few years. The profession was given great impetus by the recent Medicare legislation. In fact, the use of physical therapists under Medicare is second only to nursing as a therapeutic service. There are over 250 practicing physical therapists in Wisconsin working upon referral from physicians.

The largest number of therapists (60%) in Wisconsin work in hospitals. Curative workshops and rehabilitation centers employ 10% of therapists, and another 10% serve in schools for the handicapped. The remaining therapists work in nursing homes, home health agencies, private practice, or university teaching programs.

As with many other specialists in the health field, most physical therapists are located in larger cities. Some rural areas of the state do not have the services of a physical therapist close by.

However, the State Division of Health provides physical therapists in all parts of the state for consultation, but not for treatment. These eight consultants teach rehabilitative care techniques to nursing personnel in hospitals, nursing homes, and in home care programs.

Efforts are being stepped up now to reactivate physical therapists who are not now employed. Refresher courses are available. A course was held by the State Health Division for therapists in home care programs last April and another will be sponsored in January by the Wisconsin Physical Therapy Association, the University of Wisconsin School of Physical Therapy, and the Section of Chronic Disease and Aging. These courses and a recently completed health manpower survey in the state, are two ways to encourage more efficient use of trained health personnel in Wisconsin.

THE PRESIDENT'S PAGE

HAROLD J. KIEF, M.D.

SMS means aggressive leadership

Responsibility Educates

■ DR. MILFORD O. ROUSE, president of the American Medical Association, has mentioned many times that "doctors spend too much time with doctors and not enough with other leaders of the community." He has said that the tendency for physicians to spend their free hours exclusively with each other limits their total awareness of the community, as well as the stimulation of associating with their nonprofessional peers. This self-imposed isolation also deprives the community of the skills which doctors could bring to social, economic, and health pursuits.

One of the methods that physicians at the local level could employ to increase their knowledge of their community's health problems would be to become active in their own community's voluntary health agencies. Every city and county has several voluntary health agencies which have certain principal characteristics. They are a voluntary, nongovernmental association of citizens with a common goal or interest in the prevention and control of some disease or infirmity. Each health agency gathers voluntary contributions and expends its resources in ways decided by its own governing body for public and professional education, medical research, and medical care.

Physicians, as well as citizens, have the same interest in good health and disease prevention as others who volunteer their services. Furthermore, physicians, by their special training, must recognize the importance of these volunteer efforts to promote sound health practices at the national, state, and local levels.

The individual physician can play any one of four separate but related roles when he becomes affiliated with a voluntary health agency concerned with a phase of preventive medicine or medical care: (1) He may be delegated as an official representative of his medical association or, (2) He may be called upon by an agency to serve as a physician in ways suggested by his specific professional interest; (3) He may seek membership of his own accord and become active in an agency's program because of his special interest or, (4) He may use a health agency as a medium for public service as a private citizen interested in his community. Physician membership on boards of directors of his state and local voluntary health agencies must be encouraged, even though such physician represents the medical society only informally and not as an official spokesman.

This need of physician representation in *local voluntary* health agencies has become evident in many areas of our state. This is especially true of the Wisconsin Division of the American Cancer Society. Although over 15,000 physicians regularly participate in various programs of the American Cancer Society throughout the nation and on the state medical society level, we do need *more help* from physicians on the *local level.*

I am sure that all of the physicians know that the major portion of the funds of the American Cancer Society supports significant medical research projects and health education. Many needed community services, long-term care, and rehabilitation of chronic disease victims have been subsidized by the American Cancer Society. These services by the thousands of lay volunteers and by organized medicine are important supplements to the more formal elements of community medical care. The American Cancer Society deserves strong support of the medical profession, particularly in those scientific areas where only physicians can render effective guidance.

Physicians by becoming a *responsible* member of their local unit of the American Cancer Society or the local chapter of other voluntary health agencies can only help but educate themselves. A physician in such a role in the community is placed in the role of a teacher and counselor; and by teaching, he too continues his education.

H J Kief MD

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EDITORIALS

D. N. GOLDSTEIN, M. D., *Editorial Director*

Legislation by Regulation

■ THE INTERNAL REVENUE SERVICE has recently proposed changes in its regulations regarding the status of income derived from the journals published by tax-exempt organizations. If the proposals become enactments, the advertising income of the *Wisconsin Medical Journal*, and every other magazine published by a professional organization, would be taxed as though it were published by a commercial enterprise.

At the present time, under the Revenue Act of 1950, such publications are exempt from taxation on the grounds that their principal function is to further the purpose for which the sponsoring organization is granted exemption. Obviously, the journal of a medical society is published to promote the educational purposes of the parent organization. If the magazine accepts advertising, the income serves to reduce the cost of the publication to the members of the organization. In the instances where an operating profit occurs, the surplus income is usually used to purchase additional professional benefits for the members of the tax-exempt organization. Generally, professional magazines are of such a specialized nature and reach such a limited audience that they offer no competition to commercially operated publications whose activities come under the tax regulations governing ordinary business.

In all fairness, however, it must be admitted that the proposals of the IRS do reflect a situation that requires correction. The publications of some business and fraternal organizations, which are also tax-exempt, are circulated to the general public by means of paid subscriptions, and their advertising income is substantially higher than the cost of publishing the magazine. They compete with commercially operated publications not only for readers but also for the advertiser's dollar, and except for their affiliation with a tax-exempt organization, they are indistinguishable from a general circulation magazine. An outstanding example of this kind of periodical is *Nation's Business*, the publication of the U. S. Chamber of Commerce, which competes with *Fortune*, *Forbes*, and other business magazines for the same readers and the same advertising revenue.

Clearly, the Internal Revenue Service should make a distinction between strictly professional magazines published to advance the purpose of the sponsoring organiza-

tion and those periodicals offered to the general public which constitute business enterprises not substantially related to the purpose for which tax-exemption was originally granted. Just as the income of a shoe factory operated by a church would be taxed, so the income of a magazine published by a veterans' organization that is sold to the general public should be taxed.

The intention of Congress in the Revenue Act of 1950 was manifestly to encourage the educational characteristics of certain nonprofit organizations by subsidizing them to the extent of tax-exemption on the income of their publications. It would be a sad commentary if the IRS were to frustrate the legislative intention by changing its regulations to eliminate the tax-exempt status of professional publications. While a review and modification of the system of tax-exemption is undoubtedly in order, the IRS should be careful about wrecking the house to get at the termites.—D.N.G.

No Sounding Brass at Roche

IN THIS DAY OF institutionalized charity it is refreshing to find evidence that the ideal of person-to-person responsibility is not dead.

Such responsibility is shown by Roche Laboratories, division of Hoffmann–La Roche, Inc., manufacturer of pharmaceuticals. Roche has an indigent patient program under which a physician may obtain medication without charge for deserving patients who can't afford to buy it. All the doctor need do is to write Roche, giving a brief outline of the case. The drugs are sent directly to the doctor to be dispensed by him. Roche requires only the statement of the doctor—no names, no addresses, no statistical information, no red tape.

While almost all pharmaceutical manufacturers gladly cooperate with the physician who requests medication for indigent patients, Roche has made a program of a virtue by calling the attention of physicians to its largess, thereby encouraging its use.

From a certain point of view, elimination of private charity is a goal to be eagerly sought. Private charity tends to be highly selective at best and discriminatory at worst. As individuals we support institutions and organizations that operate closest to us or are most compatible with our background or modes of thought. That's why Catholics contribute to Catholic charities, Protestants to Protestant charities, and Jews to Jewish charities. Presumably each group takes care of its own, and this exclusivism becomes a point of pride: we take care of our own!

Tax-supported charity, on the other hand, takes the position, at least in this country and in this period, that needy are needy regardless of religious affiliation, color of skin, or ethnic background. It is colder, more impersonal, and perhaps more efficient than private charity. Because it is tax-supported and a function of the government, it has an unfortunate tendency to encourage the recipient to believe that he is entitled to charitable support. We have come a long way from the notion that to succor the poor is to promote laziness and irresponsibility among them. Nevertheless, it cannot be denied that the practical applications of the nation's compassion for the poor and the economically deprived have served also to undermine the old fashioned virtues of providence and independence.

When the government got into the business of furnishing medical care to the indigent senior citizen, it rendered pointless the thousands of personal charities by doctors all over the country. Where doctors formerly treated the poor on a person-to-person basis, without charge, the government now reimburses the doctor under the appropriate program and after the proper forms are filled out. But the medically indigent are always with us in considerable number, and there are enough of them not covered by a government program to require the continuation of personal good works on the part of physicians. This exercise in human compassion, quiet, unpublicized, non-tax-deductible and prevalent, is in keeping with the highest ideals of our profession. That Roche and other pharmaceutical manufacturers understand and support our efforts in a most meaningful manner speaks well of the essentially sensitive rapport between these elements of the health care establishment in the United States.—D.N.G.

SPECTRUM OF PATIENT CARE

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dominant nature of the requirements for skilled personnel, at a given point of time, in a therapeutic regimen.

For the emphasis in patient care services has been upon prompt and effective treatment, and dramatic results have been achieved in medical science and technology. (The nature of required patient care services prior to and following surgery will be discussed later.)

But little progress has been realized in some of the other service areas identified in the definition of comprehensive health services. Many persons are hospitalized for conditions that could have been prevented or minimized by following sound personal health practices or by carrying out medical instruction.

Victor R. Fuchs, Associate Director of Research, National Bureau of Economic Research, stated at the National Conference on Medical Costs in June 1967 that the greatest potential for improving the health of the American people is not to be found in increasing the numbers of physicians, or in forcing them into groups, or even in increasing hospital productivity, but is to be found in what people do and don't do, to and for themselves. "With so much attention given to medical care, and so little to health education and individual responsibility for personal health, we run the danger of pandering to the understandable urge to buy a quick solution to a difficult problem."

There is a shortage of educational specialists or health educators, essential for public participation and responsibility in health programs on a well-informed or intelligent basis. The nurse and the physician primarily work in a face-to-face relationship with individuals or groups with a health problem or potential health problem. Priority must be placed on coordination of the various health education programs and health communication.

An expert committee of the World Health Organization has stated:

> Every health worker who is in close contact with the people has a potential influence on the knowledge, attitudes, and health practices of the people with whom he works. In order that the best results accrue from these contacts, it is essential that doctors, nurses, midwives, environmental sanitation workers and others with a specialized health knowledge become more conscious of their educational responsibilities and approach them with confidence, optimism, and a variety of techniques.[3]

The definition of a program of health service and the availability of these services are a constant source of public debate. For the health services available to the citizens of this nation are being adversely affected in both quantity and quality by the shortages of physicians, nurses, and other members of essential and emerging health disciplines.

The forces underlying the growth in demand for health services are powerful and continue to generate constant pressure to expand the services—to expand the services irregardless of the availability of personnel and financial or physical resources. The conflicts inherent in the expression of goals for health services and the resources to achieve these goals are self-evident. For the major problem is that of talented manpower.

Attempts to provide increased services to the citizens have resulted in a further dilution of the quality of these services. For the approach has been to employ more and more personnel with less and less preparation for major responsibilities for patient and family health services.

The major problem of shortage of talented manpower has continued to affect services available through an integrated health system. A spectrum of patient care means that services will be available through a number of different types of agencies—in addition to the hospital—for people requiring a variety of personal health care services as implied in the definition by the National Commission on Communty Health Services. These services encompass: the hospital in its most comprehensive sense; extended care facilities; home care programs and related health care facilities, such as personal care and residential centers; community health programs, public and voluntary; and personal services of physicians and other health professionals. Continuity of services and coordination of these services are essential, and means must be achieved which will insure that the health professionals assume responsibility for defining their services on a community basis rather than continuing to define the service on the basis of the hospital in isolation.

Nurses participate as members of the health team in all phases of the care of people with potential or actual health problems. They provide these services in all types of agencies and social institutions including the home and the school. It is hypothesized that an objective, analytical appraisal of nurse–patient–family interactions will identify the common elements in nursing for groups of patients. The variables are the nature of the potential or actual health problem, the age, sex, culture, and the intellectual and personal resources of the individual and his family. These common elements arise from:

1. The individual's potential or actual separation from his normal life situation.
2. The individual's physiological needs and responses to a health problem or problems.
3. The individual's psycho–social needs and responses to a health problem or problems.
4. The overall plan of medical therapy, the quality of the plan, and the availability of medical supervision of the plan of medical therapy.

To be continued in the January 1968 issue

[3] World Health Organization, *Expert Committee on Training of Health Personnel in Health Education of the Public: Report*, Technical Report Series, No. 156, 1958, p. 6.

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with organizational coverage of the medicolegal, socio-economic, ancillary, and public relations aspects in the practice of medicine

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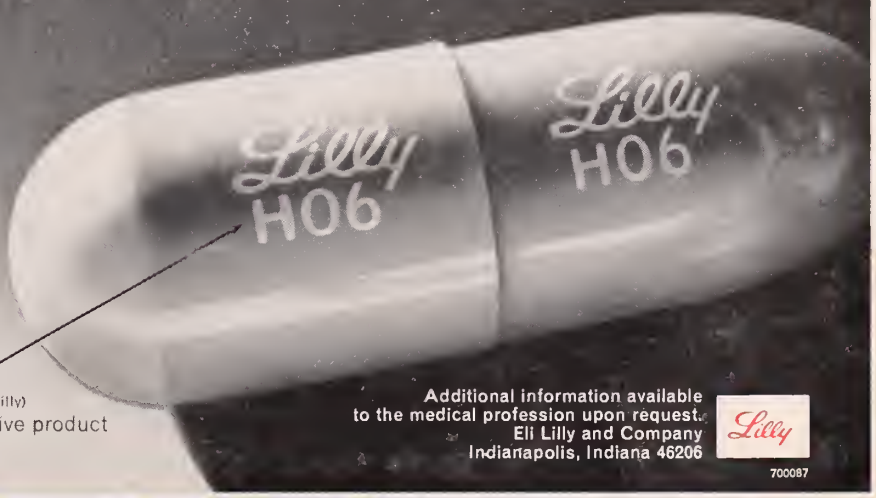

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